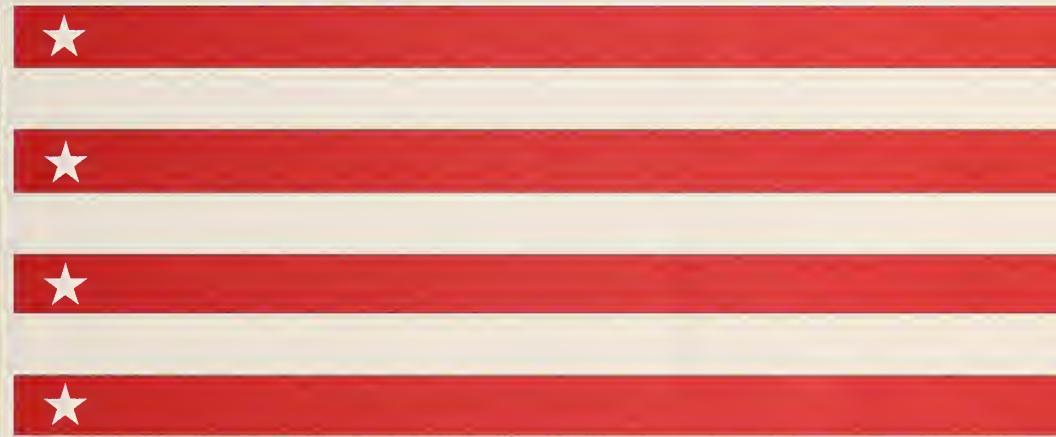


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Medicare & You



2006

This year it's different.

**Everyone needs to make a decision
about Prescription Drug Coverage.**

**Turn to Section 1 to see what you need to
do and to learn about your prescription
drug and health plan options.**

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2006

This is the official government handbook.

#5

Everyone needs to make a decision this year

Beginning January 1, 2006, Medicare will offer insurance coverage for prescription drugs through **Medicare Prescription Drug Plans** and other health plan options. Insurance companies and other private companies work with Medicare to offer these plans. **If you join by December 31, 2005, you won't miss a day of coverage.**

Because of changes in the Medicare Program, everyone with Medicare has to make a decision about prescription drug coverage this year. To learn more about these changes, see pages 39–54.

Even if you don't use a lot of prescription drugs now, you should still read the information about Medicare prescription drug coverage in this handbook and consider joining. As we age, most people need prescription drugs to stay healthy. For most people, joining now means you will pay a lower monthly premium in the future since you may have to pay a **penalty** if you choose to join later.

Keep this Handbook

This handbook describes important changes in Medicare. You can find basic information about the Medicare Program as well as specific information about each type of **Medicare Advantage Plan** or other **Medicare Health Plan** and prescription drug coverage choice.

This handbook is a good resource to have throughout the year. The information is valid for 2006, but remember this year it's different than other years. Use it in place of any older version you have. Keep it where you can find it when you need it.

How can you find the information you need in this handbook?

There are two ways to find the information you need:

1. Look at the “Table of Contents.” This lists topic areas by section, with page numbers.
2. Look at the “List of Topics” section after the table of contents. This is an alphabetical list of specific topics discussed in this handbook, with page numbers. This is the easiest way to find information.

Note: You may see words in blue in the text of this handbook. You can find definitions of these words on pages 89–92.

“Medicare & You 2006” explains the Medicare Program. It isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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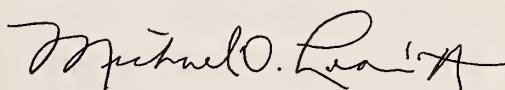
Now Medicare Covers More than Ever

Modern medicine is doing more than ever before to prevent diseases and their complications, and now Medicare is covering more of the medical care that can help you stay well. Medicare now covers preventive screenings and new options to prevent the complications of chronic diseases. Starting January 1, 2006, Medicare will provide dependable prescription drug coverage that will make it easier for everyone with Medicare to pay for the drugs they need to stay healthy.

Everyone with Medicare can choose to enroll in this voluntary drug coverage regardless of their income, health, or how they pay for prescription drugs today. Medicare prescription drug coverage is insurance that will typically pay for about half of your drug costs. It provides greater peace of mind by protecting you against ever having very high drug expenses. There is extra help for people with limited income and resources. Almost 1 in 3 people with Medicare will qualify for extra help and Medicare will pay for almost all of their prescription drug costs.

Because people with Medicare get their care in different ways, you have choices about your Medicare drug coverage. You can join a Medicare Prescription Drug Plan or you can join a Medicare Advantage Plan or other Medicare Health Plan that offers drug coverage. Whatever plan you choose, Medicare drug coverage will help you by covering brand-name and generic drugs at pharmacies that are convenient for you. And if you already have good drug coverage from your former employer or union, Medicare can help your employer or union pay for it to keep it secure.

If you need help in making a decision about Medicare's new coverage, Medicare is here for you. Use this handbook to take a new look at your Medicare. Medicare is also working with many groups in your community to give you personalized help if you need it. Medicare and many of our partners can help you make a confident decision about which Medicare plan will work for you. You can call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov to get information that is tailored just for you.



Michael O. Leavitt
Secretary
Department of Health and
Human Services



Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare &
Medicaid Services

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If you want a more detailed listing of topics in this handbook, look on the next page.

Important: The information in this handbook was correct when it was printed. Changes may occur after printing. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most up-to-date version.

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Helpful Tips

If your address changes or you need a new Medicare card

Call the Social Security Administration (SSA) at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772.

If you get more than one copy of "Medicare & You"

Call 1-800-MEDICARE (1-800-633-4227) and tell a customer service representative that your household got more than one handbook, and you want to share only one copy in the future. TTY users should call 1-877-486-2048. Please have your red, white, and blue Medicare card with you when you call. Most households with up to four people with Medicare will get one handbook to share. The handbook will be addressed to one person. This will help save money for Medicare.

Medicare Rates

Medicare premium, deductible, and coinsurance amounts for the **Original Medicare Plan** can change each year. This handbook has the 2005 rates. The 2006 rates were not available at the time of printing. To get the 2006 rates, look at www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) after January 1, 2006.

Help in your community

Medicare is working with people and organizations in your local area to help you understand the new prescription drug coverage and plan options in your community. Look for information about events in your local newspaper or listen for information on the radio. You can also get personalized counseling in your area by calling your local office on aging. For the telephone number, visit www.eldercare.gov on the web. You can also call your State Health Insurance Assistance Program (see pages 86–88 for their telephone number).

Getting Started

1

Section

New Medicare Prescription Drug Coverage

Starting January 1, 2006, Medicare will offer new prescription drug coverage. This new coverage can provide help with your drug costs, no matter how you pay for your drugs today.

This section gives you the basics about how the new drug coverage can work for you based on the type of coverage you currently have. Also, if you have limited income and resources, you can get extra help with your drug costs.

All drug plans approved by Medicare may use this seal in their materials.



Everyone with Medicare can join a drug plan to get this coverage. **And, everyone with Medicare must make a decision about their drug coverage.** That's why it's important that you read the information in Section 6 of this handbook about Medicare's new prescription drug coverage (see pages 39–54).

Remember, if you don't use a lot of prescription drugs now, you should still read the information and consider joining a Medicare drug plan. As we age, most people need prescription drugs to stay healthy. You can join as early as November 15, 2005. If you choose not to join when you are first eligible and later change your mind, you may have to pay a **penalty**.

Note: Even if you want to keep the coverage you already have, you should read the information starting on page 41 to learn how this new coverage might affect your current coverage.

Remember,
blue words in
the text are
defined on
pages 89–92.

Section 1: Getting Started

If you have the Original Medicare Plan Only or Original Medicare with a Medigap (Medicare Supplement Insurance) policy without drug coverage

Medicare prescription drug coverage will help you with your drug costs. For a typical person with Medicare, this coverage, on average, will pay 50% of your drug costs next year. Your savings could be more or less than this amount. You can take advantage of this coverage by joining a Medicare Prescription Drug Plan and keeping the rest of your Medicare coverage just the way it is. Or, you can join a Medicare Advantage Plan or other Medicare Health Plan that covers your doctor and hospital care as well as your prescriptions.

If you have the Original Medicare Plan and a Medigap (Medicare Supplement Insurance) policy with drug coverage

You will generally save money and get better coverage with the new Medicare prescription drug coverage than with your current drug coverage. Medicare coverage will never run out if you have high drug costs.

After you join a plan that offers Medicare prescription drug coverage, tell your Medigap insurer and the drug coverage portion of your Medigap policy will be removed. You won't be able to get it back. If you keep Medigap prescription drug coverage and don't join a Medicare drug plan by May 15, 2006, in most cases, you will have to pay a [penalty](#) if you choose to join later and your costs will be higher.

If you have drug coverage from an employer or union

Medicare will help employers and unions continue to provide retiree drug coverage that meets Medicare's standards.

Your employer or union will let you know if your current coverage, on average, is at least as good as the standard Medicare prescription drug coverage. This information will help you understand what decisions you will have to make. If you haven't heard from them or if you have any questions, you should contact your current or former employer or union benefits administrator.



If you are in a Medicare Advantage Plan or other Medicare Health Plan

Medicare is working with your Medicare Advantage Plan or other Medicare Health Plan to help them provide even more coverage or lower the cost of your existing coverage. Your plan will let you know about the prescription drug options they will offer. You can also choose to switch to another Medicare Advantage Plan, other Medicare Health Plan, or the Original Medicare Plan and join a Medicare Prescription Drug Plan.

If you have Medicare and Medicaid (and Medicaid now pays for your prescription drugs)

Starting January 1, 2006, you will get comprehensive prescription drug coverage from Medicare instead of Medicaid. You will get continuous prescription drug coverage from Medicare and pay very little or nothing for each covered prescription.

You must join a plan that covers prescription drugs to get drug coverage. If you don't join a plan, Medicare will enroll you in one to make sure you don't miss a day of coverage. If this happens, you can change plans at any time.

If you have Limited Income and Resources

Almost 1 in 3 people with Medicare will qualify for extra help that will cover between 85% and almost 100% of prescription drug costs.

Most people who qualify for this extra help will pay no premiums, no deductibles, and no more than \$5 for each prescription. The amount of extra help depends on your income and resources. If you qualify, you will need to join a plan to get drug coverage. Join a plan this fall so your coverage will start January 1, 2006. If you apply and qualify, and don't join a plan, Medicare will enroll you in one by May 15, 2006 to make sure you get this important coverage. To find out whether you qualify for this extra help, it's important to read the information on pages 55–62.

Section 1: Getting Started

Other new information in this handbook

In addition to the information about Medicare prescription drug coverage, this handbook includes other new information.

This information is listed below in the order it is discussed.

- **Medigap Policies**—If you have a Medigap policy with prescription drug coverage, your policy choices are changing. See pages 25–26 for information about Medigap policy changes.
- **Medicare Advantage Plans and Other Medicare Health Plans**—Medicare now gives you more choices for how to get your Medicare coverage. These plans can offer prescription drug coverage. See pages 29–38 for information about these plans.
- **Help for People with Limited Income and Resources**—If you have limited income and resources, you may qualify for extra help paying your health care costs. You might get help to pay your Medicare Part B premium, your prescription drug costs, or other health care costs. See pages 55–62 for information about programs that may help.
- **Joining and Switching Plans**—There are new rules for when you can join or switch Medicare Advantage Plans, other Medicare Health Plans, and Medicare Prescription Drug Plans. See pages 63–70 for more information about these new rules.

Medicare Insurance Basics



Section

Medicare is a health insurance program for

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has

Part A Hospital Insurance, see pages 6–7.

Most people don't pay a **premium** for Part A because they or a spouse already paid for it through their payroll taxes while working.

Part B Medical Insurance, see pages 8–14.

Most people pay a monthly premium for Part B.

Prescription Drug Coverage, see page 16.

Most people will pay a monthly premium for this coverage.

Medicare Plans (Sections 3–6)

Today's Medicare brings you more choices in how you get your health care:

- The **Original Medicare Plan**—(see page 21).
- **Medicare Advantage Plans** (see pages 29–31), including
 - Medicare **Health Maintenance Organization (HMO) Plans** (see pages 32–33).
 - Medicare **Preferred Provider Organization (PPO) Plans** (see page 33).
 - Medicare **Special Needs Plans** (see page 34).
 - Medicare **Private Fee-for-Service (PFFS) Plans** (see page 35).
- **Other Medicare Health Plans** (that aren't Medicare Advantage Plans) (see page 36).
 - Medicare Cost Plans
 - Demonstrations
 - PACE
- **Medicare Prescription Drug Plans** (see page 39).

Remember,
blue words in
the text are
defined on
pages 89–92.

Section 2: Medicare Insurance Basics

What is Medicare Part A?

Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or **long-term care**). It also helps cover hospice care and some home health care. You must meet certain conditions to get these benefits.

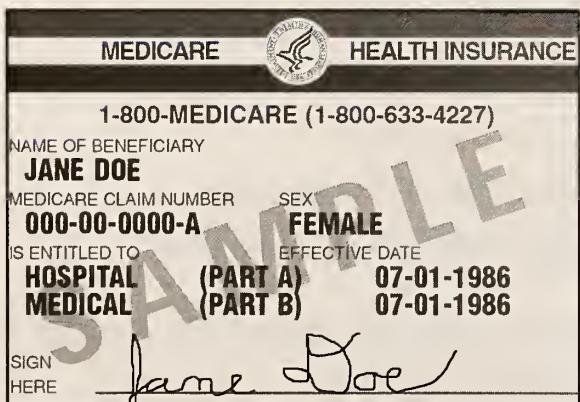
The Part A premium for people who aren't eligible for premium-free Part A is \$375.00 per month in 2005.

Cost: Most people don't have to pay a monthly payment, called a **premium**, for Part A. This is because they or a spouse paid Medicare taxes while working.

If you don't get premium-free Part A, you may be able to buy it if

- you (or your spouse) aren't entitled to Social Security, because you didn't work or didn't pay enough Medicare taxes while you worked and are age 65 or older, or
- you are disabled but no longer get free Part A because you returned to work.

If you have limited income and resources, your state may help you pay for Part A (see page 60). For more information, you can visit www.socialsecurity.gov on the web or call the Social Security Administration at 1-800-772-1213. **TTY** users should call 1-800-325-0778.



If you aren't sure if you have Part A, look on your red, white, and blue Medicare card (see sample card on the left). If you have Part A, "Hospital (Part A)" is printed on the lower left corner of your card.

Note: Earlier versions of this card are slightly different. They are still valid.

Do you need to replace your Medicare card? If your card is lost or damaged, you can order a new Medicare card at www.socialsecurity.gov on the web. Or, you can call the Social Security Administration at 1-800-772-1213. **TTY** users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772, or visit www.rrb.gov on the web and select "Mainline Services."

Section 2: Medicare Insurance Basics



Medicare Part A Helps Cover Your Medically Necessary...

Hospital Stays: Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care you get in critical access hospitals and mental health care. This doesn't include private duty nursing, or a television or telephone in your room. It also doesn't include a private room, unless **medically necessary**. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

Skilled Nursing Facility Care: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a related three-day inpatient hospital stay).

Home Health Care: Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language services that are ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Care: For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare (like grief counseling). Hospice care is usually given in your home (which may include a nursing facility if this is your home).

However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).

Blood: Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

Costs for these services vary, depending on the plan you choose (see Section 3).

Section 2: Medicare Insurance Basics

What is Medicare Part B?

Medicare Part B (Medical Insurance) helps cover your doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are **medically necessary** (see pages 9–14).

Cost: You pay the Medicare Part B **premium** each month (\$78.20 per month in 2005). In some cases, this amount may be higher if you didn't sign up for Part B when you first became eligible.

Caution: If you don't take Part B when you are first eligible, the cost of Part B will go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it, except in special cases (see employer or union coverage information on page 9). You will have to pay this **penalty** as long as you have Part B.

You also pay a Part B **deductible** each year before Medicare starts to pay its share. The Part B deductible for 2005 is \$110.00. You may be able to get help from your state to pay this premium and deductible (see page 60).

Medicare deductible and premium rates may change every year in January.

If you didn't sign up for Medicare Part B when you first became eligible, call the Social Security Administration at 1-800-772-1213 to apply. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office at 1-800-808-0772.



Medicare Part B and Group Health Plan Coverage from an Employer or Union

It's important that you understand how your Part B enrollment rights can be affected if you are or your spouse is still working, and you have coverage through an employer or union, or under COBRA (see page 72). Your decision about when to sign up for Part B can also affect your rights to buy a **Medigap policy**. For more information about enrolling in Part B, get a free copy of the booklet "Enrolling in Medicare" (CMS Pub. No. 11036) by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

Medicare Part B Helps Cover Your Medically Necessary...

Medical and Other Services: Doctors' services (not routine physical exams except for a "Welcome to Medicare" one-time physical exam within the first six months you have Part B), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). It also covers a second, and sometimes a third, surgical opinion for surgery that **isn't** an emergency (in some cases), outpatient mental health care, and outpatient occupational and physical therapy, including speech-language services. (These services are also covered for long-term nursing home residents.)

Clinical Laboratory Services: Blood tests, urinalysis, some screening tests, and more.

Home Health Care: Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy that are ordered by your doctor and provided by a Medicare-certified home health agency. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Outpatient Hospital Services: Hospital services and supplies received as an outpatient as part of a doctor's care.

Blood: Pints of blood you get as an outpatient or as part of a Part B-covered service.

Costs for these services vary, depending on the plan you choose (see Section 3, pages 19–20).

Section 2: Medicare Insurance Basics

To help you stay healthy and find health problems early, when treatment works best,

Medicare Part B covers these preventive services...

Bone Mass Measurements	<p>These measurements help determine if you are at risk for broken bones. Medicare covers these measurements once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.</p>
Cardiovascular Screenings	<p>Ask your doctor to test your cholesterol, lipid, and triglyceride levels so he or she can help you prevent a heart attack or stroke. Medicare covers screening tests for cholesterol, lipid, and triglyceride levels every five years.</p>
Colorectal Cancer Screening	<p>These tests help find precancerous growths so they can be removed and prevent cancer. They also help find colorectal cancer early, when treatment is most effective. If you are age 50 or older, or are at high risk for colorectal cancer, one or more of the following tests is covered: Fecal Occult Blood Test, Flexible Sigmoidoscopy, Screening Colonoscopy, and/or Barium Enema. How often Medicare pays for these tests depends on the test you and your doctor decide is best and your level of risk for this cancer.</p>
Diabetes Screenings	<p>Medicare covers tests to check for diabetes. These tests are available if you have any of the following risk factors: high blood pressure, dyslipidemia (history of abnormal cholesterol and tryglyceride levels), obesity, or a history of high blood sugar. Medicare also covers these tests if you have two or more of the following characteristics:</p> <ul style="list-style-type: none"> • age 65 or older, • overweight, • family history of diabetes (parents, brothers, sisters), and • a history of gestational diabetes (diabetes during pregnancy), or delivery of a baby weighing more than 9 pounds. <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. Talk to your doctor for more information.</p>
Flu Shots	<p>These shots help prevent influenza, or flu virus. Medicare covers these shots once a flu season in the fall or winter for all people with Medicare.</p>

Section 2: Medicare Insurance Basics

To help you stay healthy and find health problems early, when treatment works best,

Medicare Part B covers these preventive services...

Glaucoma Tests	These tests help find the eye disease glaucoma. Medicare covers these tests once every 12 months for people with Medicare at high risk for glaucoma.
Hepatitis B Shots	These three shots help protect people from getting Hepatitis B. Medicare covers these shots for people with Medicare at high or medium risk for Hepatitis B.
Pap Test and Pelvic Exam (includes clinical breast exam)	These exams check for cervical and vaginal cancers. Medicare covers these exams every 24 months for all women with Medicare and once every 12 months for women with Medicare at high risk.
Pneumococcal Shot	This shot helps prevent pneumococcal infections. Medicare covers this shot for all people with Medicare. Most people only need this shot once in their lifetime. Talk with your doctor.
Prostate Cancer Screening	These tests help find prostate cancer. Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50.
Screening Mammograms	These tests check for breast cancer before you or your doctor may be able to feel it. Medicare covers mammograms once every 12 months for all women with Medicare age 40 and older.
“Welcome to Medicare” Physical Exam (One-time)	Medicare covers a one-time review of your health, as well as education and counseling about the preventive services you need, including certain screenings and shots. Referrals for other care, if you need it, are also covered. Important: You must have the physical exam within the first six months you have Medicare Part B.

Section 2: Medicare Insurance Basics

Medicare Covered Items and Services

Below and on pages 13–14 is a list of common items and services Medicare covers if they are medically necessary. If an item or service you need isn't listed, call 1-800-MEDICARE (1-800-633-4227) and ask about it. **TTY** users should call 1-877-486-2048. You can also find this information at www.medicare.gov on the web.

If you have the Original Medicare Plan and need additional information about any of the listed items or services, including your share of the costs, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) for a free copy of the booklet “Your Medicare Benefits” (CMS Pub. No. 10116).

- **Ambulance services**—when it's medically necessary to be transported to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger your health
- **Chiropractic services**—manipulation of the spine to correct a subluxation (when one or more of the bones of your spine moves out of position)
- **Clinical trials**—routine costs if you take part in a qualifying clinical trial (doesn't cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial)
- **Diabetic Self-Management Training**—for certain people with Medicare at risk for complications from diabetes. Your doctor or other health care provider must request this service
- **Diabetic supplies**—glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases)
Syringes and insulin aren't covered (unless used with an insulin pump) unless you join a Medicare Prescription Drug Plan.
- **Durable medical equipment**—items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home
- **Emergency room services**—when you believe your health is in serious danger, when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse
- **Eyeglasses**—one pair of eyeglasses with standard frames after cataract surgery that includes implanting an intraocular lens

- **Foot exams and treatment**—if you have diabetes-related nerve damage and meet certain conditions
- **Hearing and balance exams**—if your doctor orders them to see if medical treatment is needed (hearing aids and exams for fitting hearing aids aren't covered)
- **Kidney dialysis services**—kidney dialysis, and services and supplies, either in a facility or at home
- **Long-term care**—only skilled care given in a certified skilled nursing facility or in your home (not custodial care)
- **Medical nutrition therapy services**—for people who have diabetes, or for people who have kidney disease (unless you are on dialysis) with a doctor's referral for three years after a kidney transplant
- **Mental health care**—inpatient or outpatient; certain limits and conditions apply
- **Practitioner services**—such as those provided by clinical social workers, physician assistants, and nurse practitioners
- **Prescription drugs**—Medicare Part B covers limited prescription drugs, like certain injectable cancer drugs. For information about more complete prescription drug coverage, see page 39.
- **Prosthetic/orthotic items**—arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy)
- **Second surgical opinions**—covered in some cases
- **Smoking cessation counseling**—inpatient or outpatient services, up to eight face-to-face visits during a 12-month period if you are diagnosed with a smoking-related illness
- **Surgical dressings**—if required for treatment of a surgical or surgically-treated wound
- **Telemedicine**—services in some rural areas
- **Tests**—X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests if medically necessary

Starting January 1, 2006, if your doctor administers drugs, like certain cancer drugs to you in the doctor's office, how you pay for your visit and the drugs may change. See page 22 for more information.



Section 2: Medicare Insurance Basics

- **Transplant services**—heart, lung, kidney, pancreas, intestine, and liver transplants (under certain conditions and in a Medicare-certified facility only), and bone marrow and cornea transplants (under certain conditions); immunosuppressive drugs if the transplant was paid for by Medicare, or paid by an employer group health plan that was required to pay before Medicare (you must have been entitled to Part A at the time of the transplant and entitled to Part B at the time you get immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility)
- **Travel (outside the United States)**—services provided in Canada when you travel between Alaska and another state. Medicare also covers hospital, ambulance, and doctor services if you are in the United States, but the nearest hospital that can treat you isn't in the United States. (The "United States" means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and for services that you received while on board a ship, the territorial waters adjoining the land areas of the United States.)
- **Urgently needed care**—care you need for a sudden illness or injury that isn't a medical emergency

Important: These items and services are covered no matter what kind of Medicare plan you have. The amount Medicare pays for these items and services depends on the type of plan you have (see pages 19–20).

Remember, you always have the right to appeal decisions about health care payment or services. See Section 10 for more information about your appeal rights.

What isn't covered by Medicare Part A and Part B?

Medicare doesn't cover everything. Items and services that aren't covered include, but aren't limited to

- acupuncture.
- deductibles, coinsurance, or copayments when you get health care services (see page 28).
- dental care and dentures (with only a few exceptions).
- cosmetic surgery.
- custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- eye refractions.
- health care you get while traveling outside of the United States (except as listed on page 14).
- hearing aids and hearing exams for the purpose of fitting a hearing aid.
- hearing tests (other than for fitting a hearing aid) that haven't been ordered by your doctor.
- long-term care, such as custodial care in a nursing home.
- orthopedic shoes (with only a few exceptions).
- prescription drugs—most prescription drugs aren't covered (see Section 6 for information about coverage for prescription drugs).
- routine foot care such as cutting of corns or calluses (with only a few exceptions).
- routine eye care and most eyeglasses (see page 12).
- routine or yearly physical exams. (Medicare will cover a one-time physical exam within the first six months you have Part B.)
- screening tests and screening laboratory tests except those listed on pages 10–11.
- shots (vaccinations) except those listed on pages 10–11.
- some diabetic supplies (like syringes or insulin unless the insulin is used with an insulin pump or you join a Medicare Prescription Drug Plan).

Some of these services may be covered if you join a Medicare Advantage Plan or other Medicare Health Plan (see page 29).



Section 2: Medicare Insurance Basics

What is Medicare prescription drug coverage?

Medicare prescription drug coverage helps cover your prescription drug costs. You must choose a plan to get this coverage. You pay a monthly premium. If you have limited income and resources, you may get this coverage for little or no cost. You can choose to take advantage of this coverage by joining a Medicare Prescription Drug Plan that covers prescription drugs only, and keep the rest of your Medicare coverage just the way it is. Or, you can join a Medicare Advantage or other Medicare Health Plan that covers your doctor and hospital care as well as prescriptions. (Note: You may already belong to one of these plans.)

Important: If you have prescription drug coverage through an employer or union, check with your benefits administrator to discuss your options (see pages 44–45).

For more information about Medicare prescription drug coverage, see Section 6 starting on page 39. For more information about the Medicare Advantage Plans, other Medicare Health Plans, or Medicare Prescription Drug Plans available in your area, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How much will my drug insurance cost?

Your costs will vary depending on your financial situation and which drug plan you choose. Check with the drug plans in your area to compare their costs and what they cover. To find the drug plans in your area, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). All drug plans will offer coverage at least as good as the Medicare minimum standard coverage. Standard coverage is described on page 53. Plans may offer more coverage and have different premiums and cost sharing.

Information about drug plan costs for people with limited income and resources is on pages 55–62.



How does Medicare Prescription Drug Coverage work if I have Employer or Union Plan Coverage?

Medicare will help employers and unions continue to provide retiree drug coverage that meets Medicare's standards. If you currently have prescription drug coverage through an employer or union that is, **on average, at least as good as** the minimum standard Medicare prescription drug coverage, you can keep it as long as it is still offered by your employer or union. Your employer will let you know if your current coverage, on average, is at least as good as the standard Medicare prescription drug coverage. You will have a Special Enrollment Period to sign up for a drug plan if your employer or union stops offering this coverage. This means you won't have to pay a **penalty** if you join a drug plan after May 15, 2006. See pages 44–45 for more information.

Where can I get help or more information if I need it?

After reading this handbook, if you need help or more information, you can

- visit www.medicare.gov on the web. This is the official Government website for people with Medicare. You can find the most up-to-date Medicare information and answers to your questions anytime.
- call 1-800-MEDICARE (1-800-633-4227). This toll-free helpline is available 24 hours a day, seven days a week to answer your questions. You can speak to a customer service representative in English or Spanish. **TTY** users should call 1-877-486-2048. You can also get free copies of Medicare booklets on such topics as **Skilled Nursing Facility Care, Hospice Care, Home Health Care, and Mental Health Care**.
- call your State Health Insurance Assistance Program (see pages 86–88 for their telephone number).
- check for local events for help enrolling in a drug plan. Contact your local Office on Aging. For the telephone number, visit www.eldercare.gov on the web.

Medicare is committed to getting you accurate and timely information about your Medicare benefits and giving you tools to make the choice that meets your needs.

Protect Yourself from Identity Theft and Fraud

Identity theft means someone uses your personal information, like your name; Social Security, Medicare, or credit card number; or other personal information, without your consent to commit fraud or other crimes.

Keep this information safe. Don't give your information to anyone who comes to your home (or calls you) uninvited selling Medicare-related products. **Only give personal information to doctors or other providers that are approved by Medicare and to people in the community who work with Medicare like your State Health Insurance Assistance Program or the Social Security Administration.** Call 1-800-MEDICARE if you aren't sure if a provider is approved by Medicare.

If you lose your Medicare card or it is stolen, or if you need a new Social Security number, go to www.socialsecurity.gov on the web, or call the Social Security Administration at 1-800-772-1213. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772, or visit www.rrb.gov on the web.

If you think someone is using your personal information, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or
- the Fraud Hotline of the HHS Office of the Inspector General at 1-800-447-8477. TTY users should call 1-800-377-4950, or
- the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report (TTY users should call 1-866-653-4261). For more information about identity theft, visit www.consumer.gov/idtheft on the web.

Medicare Prescription Drug Coverage

All prescription drug plans approved by Medicare may use this seal in their materials.



Note: Medicare plans can't contact you before October 1, 2005 about the Medicare prescription drug coverage they are offering. They also can't ask for your Social Security Number over the telephone. Report any plans that send you information about their drug coverage before this date or that ask for your Social Security Number over the telephone by calling 1-800-MEDICARE.

Section

Medicare covers many of your health care needs. Today's Medicare is working with private companies to bring new options to meet both your health care and prescription drug needs. Your decisions are important because they affect things like how much you pay and what is covered.

You can get your Medicare health care and prescription drug coverage in different ways:

- **The Original Medicare Plan**—This is a fee-for-service plan that covers many health care services and certain drugs. You can go to any doctor or hospital that accepts Medicare.

Section 4 describes the Original Medicare Plan, including how it works, what your costs are, and how you can buy a **Medigap** (Medicare Supplement Insurance) **policy** and join a Medicare Prescription Drug Plan to cover costs not covered in Original Medicare.

- **Medicare Advantage Plans and Other Medicare Health Plans**—These plans, which include HMOs, PPOs, and PFFS plans, may cover more services and have lower out-of-pocket costs than the Original Medicare Plan. However, in some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals.

Section 5 describes Medicare Advantage Plans and Other Medicare Health Plans, including what they are, how they work, how you can get a Medicare health plan that includes prescription drug coverage, and your costs.

- **Medicare drug plans**—Medicare prescription drug coverage starts January 1, 2006. You can get prescription drug coverage no matter how you get your Medicare health care.

Section 6 describes Medicare prescription drug coverage and explains how you can add this important coverage by joining a Medicare Prescription Drug Plan. It also explains how this new prescription drug coverage may affect any prescription drug coverage you may already have.

Everyone with Medicare needs to make a decision this year about Medicare prescription drug coverage, even if your decision is to keep your current coverage.

Remember,
blue words in
the text are
defined on
pages 89–92.



Section 3: Medicare Coverage Options

Do you have other health or prescription drug coverage?

If you have, or are eligible for other types of health or prescription coverage, for instance, from an employer or union, TRICARE, the Department of Veteran's Affairs, a special program, or a [Medigap policy](#), read all the materials you get from your insurer or plan provider. Talk to your benefits administrator, insurer, or plan provider before you make any changes to your current coverage.

Things to consider when choosing your Medicare coverage

- **Cost**—What will you pay out-of-pocket, including premiums?
- **Benefits**—Are extra benefits and services, like additional drug coverage, eye exams or hearing aids covered? (These may be covered by some plans.)
- **Doctor and hospital choice**—Can you see the doctor(s) you want to see? Do you need a referral to see a specialist? Can you go to the hospital you want?
- **Convenience**—Where are the doctors' offices? What are their hours? Is there paperwork? Are they accepting new patients? Do you spend part of each year in another state?
- **Prescription drugs**—Are they covered? Are your prescription drugs on the plan's list of covered drugs (formulary)?
- **Pharmacy choice**—Can you use the pharmacy you want? Are the pharmacies convenient?
- **Quality of care**—How is the quality of the plans in your area? Information about quality is available at www.medicare.gov on the web.

Look for Medicare-related events in your local area.

Choosing the health care and prescription drug coverage that works for you is an important decision. You can get personalized help.

1. Visit www.medicare.gov on the web. Select “Search Tools” at the top of the page.
2. Call 1-800-MEDICARE (1-800-633-4227). Follow the instructions to speak to a customer service representative who will help you get your personalized information. You will get your results in the mail within three weeks.
3. Call your State Health Insurance Assistance Program (see pages 86–88 for their telephone number). You can get help over the telephone or in person.

Original Medicare Plan



Section

What is the Original Medicare Plan?

The Original Medicare Plan is one of your health plan choices as part of the Medicare Program. You will stay in the Original Medicare Plan unless you choose to join a Medicare Advantage Plan or other Medicare Health Plan.

How does the Original Medicare Plan work?

The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. The rules for how the Original Medicare Plan works are below.

- You use your red, white, and blue Medicare card when you get health care (see the sample card on page 6).
- If you have Medicare Part A, you get all the Part A-covered services listed on page 7.
- If you have Medicare Part B, you get all the Part B-covered services listed on pages 9–14. You usually pay a monthly premium for Part B (\$78.20 in 2005).
- You can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility.
- You pay a set amount for your health care (**deductible**) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (**coinsurance** or **copayment**) for covered services and supplies (unless you have a Medigap policy).

Remember,
blue words in
the text are
defined on
pages 89–92.

For more detailed information about Medicare-covered items and services discussed in this section, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get a free copy of “Your Medicare Benefits” (CMS Pub. No. 10116).

Section 4: Original Medicare Plan

- After you get a health care service, each month you get a Medicare Summary Notice (MSN) in the mail. These notices are sent by companies that handle bills for Medicare. The notice lists the details of the services you received and the amount you may be billed. For more information about the Medicare Summary Notice, visit www.medicare.gov on the web and select “Medicare Billing.” You can also call 1-800-MEDICARE (1-800-633-4227) and say “Billing.”

NEW

If you get Medicare Part B drugs (like certain cancer drugs) during your doctor’s visit, you may get two Medicare Summary Notices. One notice will be for your doctor’s visit. The second notice will have the name and address of the company where your doctor ordered the drug. This notice will let you know if the claim for your doctor-administered drug is approved or denied. If you disagree with the information on the MSNs or with any bill you receive, you can file an appeal. You will get information from your doctor on how to ask for an appeal. This information is also on the MSN.

Your costs in the Original Medicare Plan

What you pay out-of-pocket depends on

- whether you have Part A and/or Part B (most people have both).
- whether your doctor or supplier accepts “assignment” (see page 24).
- how often you need health care.
- what type of health care you need.
- whether you choose to get services or supplies not covered by Medicare. In this case, you would pay all the costs for these services yourself.
- whether you have other health insurance coverage that works with Medicare.

The chart on the next page shows what you pay in the Original Medicare Plan for common services in 2005. For details about these covered services, see page 7 for Part A and pages 9–14 for Part B. You can also visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) for a free copy of the booklet “Your Medicare Benefits” (CMS Pub. No. 10116).

See Sections 7 and 9 for information about help to cover the costs that the Original Medicare Plan doesn’t cover.



Your Original Medicare Plan costs in 2005

If you have Medicare Part A and/or Part B, you will have to pay a part of the services you get. Below is a list of some of the costs you may have to pay. These costs can change each year. This handbook has the 2005 rates.

The 2006 rates were not available at the time of printing. If you want to know the costs for a specific service, visit www.medicare.gov on the web for this information. You can also call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of "Your Medicare Benefits" (CMS Pub. No. 10116).

- \$110.00 Medicare Part B deductible
- \$912.00 for a hospital stay of 1–60 days each **benefit period**
- \$228.00 per day for days 61–90 of a hospital stay each benefit period
- \$465.00 per day for days 91–150 of a hospital stay each benefit period
- All costs for each day of a hospital stay over 150 days
- \$0 for the first 20 days of a skilled nursing facility stay each benefit period
- \$114.00 per day for days 21–100 of a skilled nursing facility stay each benefit period
- All costs for each day of a skilled nursing facility stay after day 100 in the benefit period
- 20% of the **Medicare-approved amount** for most doctor services, outpatient therapy, preventive services, and durable medical equipment
- \$0 for Medicare-approved home health services
- \$0 for Medicare-approved clinical laboratory services
- 50% for most outpatient mental health services
- All costs for the first three pints of blood you get as part of an inpatient hospital stay (unless you or someone else donates blood to replace what you use)
- All costs for the first three pints of blood you get as an outpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless you or someone else donates blood to replace what you use)
- Copayments and coinsurance amounts for other services

Note: In 2006, there may be limits on physical therapy, occupational therapy, and speech-language services. For more information, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Note: To get the 2006 rates, look at www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) after January 1, 2006.



Section 4: Original Medicare Plan

What is “assignment” in the Original Medicare Plan and why is it important?

Assignment is an agreement between people with Medicare, their doctors and other providers, and Medicare. The person with Medicare agrees to let the doctor or other provider request direct payment from Medicare for covered Part B services, items, and supplies. Doctors or providers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare **deductible** and **coinsurance** amounts from the person with Medicare, their other insurance, or anyone else.

If assignment isn't accepted, doctors and providers may charge you more than the **Medicare-approved amount**. For most services, there is a limit on the amount over the Medicare-approved amount your doctors and providers can bill you. The highest amount of money you can be charged for a Medicare-covered service by doctors and other providers who don't accept assignment is called the **limiting charge**. The limiting charge is 15% over Medicare's approved amount. The limiting charge applies only to certain services and doesn't apply to supplies and items. **In addition, you may have to pay the entire charge at the time of service.** Medicare will send you its share of the charge when the claim is processed.

In some cases, your health care providers and suppliers must accept assignment. For example, if you get Medicare Part B-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare Program, the pharmacy or supplier must accept assignment.

Caution: If you get your Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare Program, you may have to file your own claim for Medicare to pay.

Doctors and other providers generally have to submit your claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can't charge you for this service.

To get more information about assignment, get a free copy of “Does your doctor or supplier accept assignment?” (CMS Pub. No. 10134) or to find doctors and suppliers who participate in Medicare, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. You can also call 1-800-MEDICARE (1-800-633-4227) for this information.



Other Plans that Supplement the Original Medicare Plan

1.

Medigap (Medicare Supplement Insurance) Policies

The Original Medicare Plan pays for many health care services and supplies, but it doesn't pay all of your health care costs or cover prescription drugs. To help cover extra health care costs, you might want to get a [Medigap policy](#). Starting January 1, 2006, you won't be able to buy new Medigap policies covering prescription drugs because private companies approved by Medicare will offer this coverage.

What is a Medigap policy?

A Medigap policy is a health insurance policy sold by private insurance companies. They must follow federal and state laws. These laws protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."

Costs that you must pay, like coinsurance, copayments, and deductibles, are called "gaps" in Original Medicare Plan coverage. You might want to consider buying a Medigap policy to cover these gaps in Original Medicare coverage. Some Medigap policies also cover benefits that the Original Medicare Plan doesn't cover, like emergency health care while traveling outside the United States. A Medigap policy may help you save on out-of-pocket costs. If you buy a Medigap policy, you will pay a monthly premium to the private insurance company that sells you the policy.

In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 12 standardized policies (Plans A–L) so you can compare them easily. Each plan has a different set of benefits. Plans K and L are new policies that help limit high out-of-pocket costs for doctor's services and hospital care. They may already be available in some states. They will likely have a lower premium than other Medigap policies. However, unlike Plans A–J, you will pay more of Medicare's coinsurance and deductibles before the policy pays its share of these costs.

Two of the standardized policies (Plans F and J) may have a high-deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT policies usually cost less because you must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, you may use any doctor or hospital.



Section 4: Original Medicare Plan

How does the Original Medicare Plan work with a Medigap policy?

- You may go to any doctor, specialist, or hospital (unless you buy a Medicare SELECT policy). Medicare pays its share, and then your **Medigap policy** pays its share. What your Medigap policy covers depends on which plan (Plan A-L) you buy. However, Medigap policies generally cover Medicare's coinsurance, copayments, and deductibles.
- You pay your monthly Medicare Part B premium, and you pay the insurance company a monthly premium for your Medigap policy.
- After you get a health care service, in most cases each month you will get a Medicare Summary Notice in the mail and your Medigap insurance company will send you information on what it paid on your behalf.

If you already have a Medigap policy with **prescription drug coverage**, you can keep that policy with **drug coverage** or you may want to join a Medicare Prescription Drug Plan to save money and limit high out-of-pocket costs for prescription drugs. You pay all the costs for your Medigap drug coverage, but, if you join a Medicare Prescription Drug Plan, Medicare pays most of the premium for standard coverage. Medicare prescription drug coverage is also better than the drug coverage in most Medigap plans. If you keep Medigap prescription drug coverage and don't join a Medicare drug plan by May 15, 2006, you will have to pay a **penalty** if you choose to join later and your costs will be higher. See page 47 for more information about your drug coverage choices that may save you money.

For more information about Medigap policies, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and say "Publications" to get a free copy of "Choosing A Medigap Policy: A Guide to Health Insurance For People With Medicare" (CMS Pub. No. 02110).

What if I have a limited income and can't afford a Medigap Policy?

There are other types of programs that might help you pay costs Medicare doesn't cover (see pages 55–62 and 71–74). You might also want to join a Medicare Advantage Plan or other Medicare Health Plan to get help with coinsurance, deductibles, and drug costs (see pages 29–38).

2.

Medicare Prescription Drug Plans

What is a Medicare Prescription Drug Plan?

Starting January 1, 2006, new Medicare Prescription Drug Plans will be available to all people with Medicare. See pages 39–54 for more details about the new Medicare Prescription Drug Plans.

How does the Original Medicare Plan work with a Medicare Prescription Drug Plan?

- You pay a separate monthly premium for your prescription drug plan.
- You pay a copayment or coinsurance, and deductible for your prescription drugs.
- You get a prescription card from your Medicare Prescription Drug Plan. Show it when you get your prescriptions filled.
- You must go to pharmacies that belong to (are in the network of) the Medicare Prescription Drug Plan that you join. If you go to a pharmacy that isn't part of the plan you join, in most cases, your drug won't be covered and you will have to pay the full cost of the drug.
- Each Medicare Prescription Drug Plan has a list of covered prescription drugs which may vary from plan to plan. In most cases, only drugs on this list will be covered.

What if I have a limited income and can't afford a Medicare Prescription Drug Plan?

People with Medicare and Medicaid, and other people with limited income and resources can qualify for help paying their Medicare Prescription Drug Plan costs. See the chart on pages 57–58 to see what your costs would be if you qualify for help. You might also want to join a Medicare Advantage Plan or other Medicare Health Plan (see pages 29–38).

Remember: If you have drug coverage through a previous or current employer or union, contact your benefits administrator before you make any changes to your prescription drug coverage.



Section 4: Original Medicare Plan

How Your Bills Get Paid If You Have Other Health Insurance

Sometimes your other insurance pays your health care bills first and the **Original Medicare Plan** pays second. Other insurance that may pay first includes the following: employer group health plan coverage when coverage is based on your or a family member's current employment, no-fault insurance, liability insurance, black lung benefits, and workers' compensation. In most cases, these types of insurance must pay first. It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly.

In some cases, if the insurance that is supposed to pay first doesn't pay promptly, the Original Medicare Plan may make a "conditional" payment. The Medicare payment is conditional because it must be repaid to Medicare when the insurance that is supposed to pay first makes a payment.

If you are in the Original Medicare Plan and you have questions about who pays first or you need to update your other health insurance information, call the Coordination of Benefits Contractor at 1-800-999-1118. **TTY** users should call 1-800-318-8782. For more information, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) and say "Publications" to get a free copy of "Medicare and Other Health Benefits: Your Guide to Who Pays First" (CMS Pub. No. 02179).

Note: If you have other insurance that pays for your prescriptions and you join a Medicare Prescription Drug Plan, you must let your Medicare Prescription Drug Plan know about your other coverage.

Medicare Advantage Plans and Other Medicare Health Plans



Section

What are Medicare Advantage Plans?

Medicare Advantage Plans are health plan options that are part of the Medicare Program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. In most of these plans, generally there are extra benefits and lower copayments than in the Original Medicare Plan. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services.

Medicare Advantage Plans include Medicare HMOs (see pages 32–33), Medicare PPOs (see page 33), Medicare Special Needs Plans (see page 34), and Medicare Private Fee-for-Service Plans (see page 35).

**Remember,
blue words
in the text
are defined
on pages
89–92.**

What are the other Medicare Health Plans?

There are some types of Medicare Health Plans that are not part of Medicare Advantage. However, they are still part of the Medicare Program. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage can include prescription drug coverage. Medicare pays a set amount of money for your care every month to these private health plans.

These other types of Medicare Health Plans include Medicare Cost Plans (see page 36), Demonstrations (see page 36), and PACE (Programs of All-inclusive Care for the Elderly, see page 61).

Page 30 provides a brief description of some of the different types of Medicare Advantage Plans and Medicare Health Plans.

Section 5: Medicare Advantage Plans and Other Medicare Health Plans

1.

Medicare Advantage Plans

- Medicare Health Maintenance Organization (HMOs) Plans — You generally must get your care from primary care doctors, specialists, or hospitals on the plan's list (network) except in an emergency (see pages 32–33).
- Medicare Preferred Provider Organization (PPOs) Plans — In most of these plans, you pay less if you use primary care doctors, specialists, and hospitals on the plan's list (network). You can go to any doctor, specialist, or hospital not on the plan's list, but it will usually cost extra, (see page 33).
- Medicare Special Needs Plans — These plans provide health care coverage designed for specific groups of people (see page 34).
- Medicare Private Fee-for-Service (PFFS) Plans — If you join one of these plans, you can go to any primary care doctor, specialist, or hospital that accepts the terms of the plan's payment. The private company, rather than the Medicare Program, decides how much it will pay and how much you pay for the services you get (see page 35).

2.

Other Medicare Health Plans

- Medicare Cost Plans — In these plans, you can use primary care doctors, specialists, and hospitals on the plan's list (network). However, unlike Medicare Advantage Plans, if you get services from a non-network provider, they are covered under the Original Medicare Plan. Coverage in Medicare Cost Plans can include prescription drug coverage. These plans don't provide free additional benefits or savings on your Medicare Part B or prescription drug coverage premiums (see page 36).

Note: There are a limited number of Medicare Cost Plans.

- Demonstrations — These plans are special projects that test possible future improvements in Medicare coverage, costs, and quality of care (see page 36).
- PACE (Programs of All-inclusive Care for the Elderly) — PACE combines medical, social, and long-term care services for frail elderly people (see page 61).

If Medicare Advantage Plans and other Medicare Health Plans are available in your area, and you have Medicare Part A **and** Part B, you can join one and get your Medicare-covered benefits through the plan.

If you are already in a Medicare **HMO** and have only Part B, you may stay in your plan. You may also have to pay a monthly **premium** for the extra benefits and prescription drug coverage.

Note: If you have End-Stage Renal Disease, see page 66. You may not be able to join and the plan may have special rules that you need to follow.

If you join a Medicare Advantage Plan or Other Medicare Health Plan

- you are still in the Medicare Program.
- you still have Medicare rights and protections (see Section 10).
- you still get all your regular Medicare-covered services (see pages 7 and 9–14).
- you may be able to get prescription drug coverage through the plan. If you are in most Medicare Advantage Plans and other Medicare Health Plans, you must get your Medicare prescription drug coverage from the plan if it's offered. If you have a Medicare Private Fee-for-Service Plan that doesn't offer Medicare prescription drug coverage, or if you have a Medicare Cost Plan, you can join a Medicare Prescription Drug Plan.
- you may be able to get extra benefits, such as coverage for vision, hearing, dental and/or health and wellness programs. However, you may have to see doctors that belong to the plan to get these services.
- what you pay out-of-pocket in addition to the Part B premium depends on the plan's monthly premium amount. Medicare Advantage Plans and other Medicare Health Plans will have one premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and any extra benefits (if offered).
- you will have to pay other costs (such as **copayments** or **coinsurance**) for the services you get. Generally, your out-of-pocket costs in these plans are lower than in the Original Medicare Plan.

For more information about the Medicare Advantage Plans and other Medicare Health Plans available in your area, you can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the most up-to-date and detailed health plan information. **TTY** users should call 1-877-486-2048.

Section 5: Medicare Advantage Plans and Other Medicare Health Plans

1.

Medicare Advantage Plans

Medicare Health Maintenance Organization (HMO) Plans

These are the general rules for how Medicare HMOs work. For some of these rules, plans may differ slightly, so it's important to read plan materials carefully.

- In most Medicare HMOs, there are doctors and hospitals that join the plan (called the plan's "network"). You generally must get your care and services from the plan's network. Call or get a list from the plan to see which doctors and hospitals are in the plan's network.
- If you join a plan, you may be asked to choose a primary care doctor. Your primary care doctor is the doctor you see first for most health problems. In many HMOs, you must see your primary care doctor before you can see any other health care provider.
- If you want to keep seeing your current doctor, call and ask if he or she is in the Medicare HMO and can continue to see you if you join the plan. If not, you may want to ask your doctor for a recommendation or choose a different plan.
- If you want to change your primary care doctor, you can ask your plan for the names of other plan doctors in your area.
- Doctors can join or leave Medicare HMOs. If your primary care doctor should leave your plan, your plan will notify you in advance and give you a chance to pick a new doctor.
- If you get health care outside of the plan's network, you may have to pay for these services yourself. In some cases, neither the Medicare HMO nor the Original Medicare Plan will pay for these services.
- The service area is where the plan accepts members and where plan services are provided. You are covered if you need emergency or urgently needed care and you aren't in your HMO's service area (see pages 12 and 14).
- You usually need a **referral** to see a specialist (such as a cardiologist). A referral is a written OK from your primary care doctor for you to see a specialist or get certain services.
- There are special rules for certain services. If you are a woman, you can go once a year, without a referral for a screening mammogram. You can go every other year to a specialist in the network for Medicare-covered routine and preventive women's care services. If the type of specialist you need isn't available, the plan will arrange for care outside the network.

Section 5: Medicare Advantage Plans and Other Medicare Health Plans



- Some Medicare HMOs offer a [Point-of-Service](#) option. This allows you to go to other doctors and hospitals who aren't a part of the plan ("out-of-network"), but you may pay more.
- If your Medicare HMO includes prescription drug coverage, you will pay a copayment or coinsurance for each covered prescription (unless you have Medicare and Medicaid, and are in an institution like a nursing home).

Medicare Preferred Provider Organization (PPO) Plans

Medicare PPOs use many of the same rules as Medicare HMOs listed above and on page 32.

However, generally in a PPO you can see any doctor or provider that accepts Medicare. You don't need a [referral](#) to see a specialist or any provider out-of-network. If you go to doctors, hospitals, or other providers who aren't part of the plan ("out-of-network" or "non-preferred"), you will usually pay more. You may want to contact the plan before you get services to find out how much you will have to pay and to determine if the service you want is covered.

Generally, you will get more benefits for lower costs than the Original Medicare Plan. Every PPO plan must pay for all covered services you get out-of-network, but every plan is different in what you must pay. Contact the PPO plan you are interested in to find out more.

NEW

Starting in 2006, regional PPOs will be available in most areas of the country to give choices for Medicare health care coverage. Also, local PPOs are now available in more areas of the country. Unlike **local** PPOs, which serve individual counties, **regional** PPOs will serve an entire region, which may be a single state or multi-state area. This will help bring more plan options to people with Medicare. Just like local PPOs, regional PPO members also will be able to get their Medicare prescription drug coverage from the PPO plan. In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits. There will be an annual limit on their out-of-pocket costs. This limit will vary depending on the plan.



Section 5: Medicare Advantage Plans and Other Medicare Health Plans

Medicare Special Needs Plans

In 2005, Medicare Health Plans started to offer “Special Needs” Plans. These plans may limit all or most of their membership to people

- in certain long-term care facilities (like a nursing home),
- eligible for both Medicare and Medicaid, or
- with certain chronic or disabling conditions.

Special Needs Plans are available in limited areas. The Special Needs Plan must be designed to provide Medicare health care and services to people who can benefit the most from things like special expertise of the plan’s providers, and focused care management. Special Needs Plans also must provide Medicare prescription drug coverage. In most of these plans, generally there are extra benefits and lower copayments than in the Original Medicare Plan.

For example, a Special Needs Plan for people with diabetes might have additional providers with experience caring for conditions related to diabetes, have focused special education or counseling, and/or nutrition and exercise programs designed to help control the condition. A Special Needs Plan for people with both Medicare and Medicaid might help members access community resources and coordinate many of their Medicare and Medicaid services.

To find out if any Medicare Special Needs Plans are available in your area

- visit www.medicare.gov on the web. Select “Search Tools” at the top of the page.
- call 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048.

Section 5: Medicare Advantage Plans and Other Medicare Health Plans



Medicare Private Fee-for-Service (PFFS) Plans

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies. The general rules for how Medicare Private Fee-for-Service Plans work are below.

- You can go to any Medicare-approved doctor or hospital that accepts the terms of your plan's payment.
- You may get extra benefits not covered under the [Original Medicare Plan](#), such as extra days in the hospital.
- The private company, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get.
- If you're in a Medicare Private Fee-for-Service Plan, you can get your Medicare prescription drug coverage from the plan if it's offered, or you can join a separate Medicare Prescription Drug Plan to add prescription drug coverage if drug coverage isn't offered by the plan.

2.

Other Medicare Health Plans

Medicare Cost Plans

These are the general rules for how Medicare Cost Plans work. For some of these rules, plans may differ slightly, so it's important to read plan materials carefully.

- Medicare Cost Plans are available in limited areas of the country.
- Medicare Cost Plans use many of the same rules as Medicare HMOs listed on pages 32–33. However, in a Medicare Cost Plan
 - if you go to a non-network provider, the services are covered under the Original Medicare Plan. You would pay the Medicare Part A and Part B coinsurance and deductibles.
 - you can join a Medicare Cost Plan anytime it is accepting new members.
 - you can leave a Medicare Cost Plan at any time and return to the Original Medicare Plan.
 - you can either get your Medicare prescription drug coverage from the plan if it's offered, or you can buy a separate Medicare Prescription Drug Plan to add prescription drug coverage.

Demonstrations

Demonstrations are special projects that test possible future improvements in Medicare coverage, costs, and quality of care. Demonstrations are usually for a specific group of people and/or are offered only in specific areas. The results of demonstrations have helped shape many of the changes in Medicare over the years. To find more information about demonstrations you can join, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

PACE (Programs of All-inclusive Care for the Elderly)

PACE plans are offered in some states as an option under Medicaid. For information about PACE, see page 61.

Your costs in a Medicare Advantage Plan and Other Medicare Health Plans

What you pay out-of-pocket each year depends on

- whether the plan charges a monthly **premium** in addition to your monthly Part B premium (\$78.20 in 2005). Medicare Advantage Plans and other Medicare Health Plans will have one premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and extra benefits (if offered).
- whether the plan reduces the monthly Medicare Part B premium (see below).
- how much you pay for each visit or service.
- the type of health care you need and how often you get it.
- the types of extra benefits you need, whether the plan covers them, and whether they charge an additional premium.

Saving on Your Medicare Part B Premium

Some Medicare Advantage Plans may pay all or part of your Medicare Part B premium. If you join a plan that offers this benefit, it may save you money. You would still get all Medicare Part A and Part B-covered services.

Medicare Advantage Plans with Prescription Drug Coverage

Most Medicare Advantage Plans already provide some coverage for prescription drugs. In 2006, more Medicare Advantage Plans now have an option for prescription drug coverage that provides even more help with drug costs. If your Medicare Advantage Plan decides to offer Medicare prescription drug coverage and you want this coverage, you must take the drug coverage your plan is offering. Or, you can join another plan or return to the Original Medicare Plan and join a Medicare Prescription Drug Plan. If you are currently enrolled in a Medicare Advantage Plan, you will get information from your plan this fall that explains your coverage options for next year.

Note: Medicare prescription drug coverage is voluntary. In some cases, Medicare Advantage Plans or other Medicare Health Plans don't offer prescription drug coverage and, in those cases, you can keep your current coverage or switch to the Original Medicare Plan if you don't want prescription drug coverage. However, if you first join a Medicare drug plan after May 15, 2006, you will pay a **penalty**.



Section 5: Medicare Advantage Plans and Other Medicare Health Plans

Saving on Your Prescription Drug Coverage Premium

You may have to pay a premium for Medicare prescription drug coverage, like you pay for Medicare Part B. Some **Medicare Advantage Plans** and other **Medicare Health Plans** may pay all or part of your prescription drug coverage premium. If you join a plan that offers this benefit, it may save you money. You should read the plan materials carefully before joining to see if the Medicare Advantage Plan or other Medicare Health Plan you are interested in offers lower prescription drug coverage premiums. Plans decide each year if they will reduce part or all of your prescription drug coverage premium.

How Your Bills Get Paid If You Have Other Health Insurance

Sometimes your other insurance pays your health care bills first and your Medicare Advantage Plan or other Medicare Health Plan pays second. Other insurance that may pay first includes employer group health plan coverage (when coverage is based on your or a family member's current employment), no-fault insurance, liability insurance, black lung benefits, and workers' compensation. It's important that you tell your doctor and hospital that you have other insurance so they will know how to handle your bills correctly. If you have questions about who pays first, or you need to update your other health insurance information, call the Coordination of Benefits Contractor at 1-800-999-1118. TTY users should call 1-800-318-8782. For more information about who pays first, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get a free copy of "Medicare and Other Health Benefits: Your Guide to Who Pays First" (CMS Pub. No. 02179).

Medicare Prescription Drug Coverage



Section

What is Medicare Prescription Drug Coverage?

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. You choose the drug plan and pay a monthly premium. Like other insurance, if you decide not to enroll in a drug plan when you are first eligible, you may pay a **penalty** if you choose to join later.

There are two types of Medicare plans that provide insurance coverage for prescription drugs. There will be prescription drug coverage that is a part of Medicare Advantage Plans and other Medicare Health Plans. You would get all of your Medicare health care through these plans. There will also be Medicare prescription drug coverage that adds coverage to the Original Medicare Plan, and some Medicare Cost Plans and Medicare Private Fee-for-Service Plans. These plans will be offered by insurance companies and other private companies approved by Medicare. Both types of plans are referred to as drug plans in this section.

If your employer or union offers you drug coverage, you might not need to join a Medicare drug plan (see pages 44–45).

Remember,
blue words in
the text are
defined on
pages 89–92.

Like other insurance, if you join a plan offering Medicare drug coverage there is a monthly premium. If you have limited income and resources, you may get extra help to cover prescription drugs for little or no cost. The amount of the monthly premium is not affected by your health status or how many prescriptions you need. You will also pay a share of the cost of your prescriptions. All drug plans will have to provide coverage at least as good as the standard coverage, which Medicare has set (see page 53). However, some plans might also offer more coverage and additional drugs for a higher monthly premium.

If you have limited income and resources, you may be able to get help with drug plan costs (see pages 55–62).

You Need To Make An Important Decision About Your Prescription Drug Coverage.

The prescription drug coverage option you choose affects

- **Coverage**

Medicare drug plans will cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. This makes sure people with different medical conditions can get the treatment they need.

Most plans will have a **formulary**, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when plans get new information. Your plan must let you know at least 60 days before a drug you use is removed from the list or if the costs are changing.

If your doctor thinks you need a drug that isn't on the list, or if one of your drugs is being removed from the list, you or your doctor can apply for an exception or appeal the decision.

- **Cost**

Monthly premiums and your share of the cost of your prescriptions will vary depending on which plan you choose. If you have limited income or resources, you may qualify for extra help paying your drug plan costs (see Section 7).

- **Convenience**

Drug plans must contract with pharmacies in your area. Check with the plan to make sure the pharmacies in the plan are convenient to you. Some plans also allow you to get your prescriptions through the mail.

- **Security Now and in the Future**

Even if you don't take a lot of prescription drugs now, you still should consider joining a drug plan in 2006. As we age, most people need prescription drugs to stay healthy. For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a plan by May 15, 2006, and you don't currently have a drug plan that, on average, covers at least as much as standard Medicare prescription drug coverage, you will have to wait until November 15, 2006 to join. When you do join, **your premium cost will go up at least 1% per month for every month that you wait to join**. Like other insurance, you will have to pay this **penalty** as long as you have Medicare prescription drug coverage. If you join by December 31, 2006, your coverage will begin January 1, 2007.



Help with Prescription Drug Coverage Decisions

Everyone needs to make a decision about prescription drug coverage. Although all Medicare drug plans must meet Medicare's standards, there are many things to think about to help you choose a plan that meets your needs. This handbook is organized to help you quickly get the information you need. You might fit into more than one of these groups. If you need help to see where you fit, call your [State Health Insurance Assistance Program](#) (see pages 86–88 for their telephone number). You can also visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Important: Prescription drug coverage is insurance. It's NOT doctor samples, discount cards, Medicare-approved drug discount cards with or without the \$600 credit, free clinics, or drug discount websites.

The charts on the next two pages help guide you to the information that applies to your personal situation.

- If you **currently have** prescription drug coverage, see the chart on page 42.
- If you **currently do not have** prescription drug coverage, see the chart on page 43.

People with limited income and resources may qualify for extra help paying the costs of their prescription drug coverage (see pages 55–62).

Medicare is working with other government representatives, community and faith-based groups, employers and unions, doctors, pharmacies and other people and organizations at the local level to help you understand the new prescription drug coverage and plan options in your community. Look for information about events in your local newspaper or listen for information on the radio. You can also get personalized counseling by calling your local office on aging. For the telephone number, visit www.eldercare.gov on the web.

Remember, this new coverage can provide help with your drug costs and security for the future, no matter how you pay for your drugs today.

Section 6: Medicare Prescription Drug Coverage

What To Do If You **CURRENTLY HAVE** **Prescription Drug Coverage**

Your current coverage may change when Medicare prescription drug coverage starts January 1, 2006. If you have limited income and resources, see pages 55–62.

Does your (or your spouse's) current or former employer or union provide your prescription drug coverage?

- See pages 44–45 for more information.

AND

- Look for information from your benefits administrator to find out if and how your coverage may be affected. Contact them if you have questions.

OR

Does your prescription drug coverage come from

- **a Medicare Advantage Plan or other Medicare Health Plan?** See page 46 for information about your drug coverage choices.
- **a Medigap (Medicare Supplement Insurance) policy?** See page 47 for information about your drug coverage choices.
- **your state Medicaid program?** See page 49 to learn how your prescription drug coverage will change on January 1, 2006.
- **TRICARE, the Department of Veteran's Affairs, or FEHB?** See page 48.

Important: Prescription drug coverage is insurance. It's NOT doctor samples, discount cards, Medicare-approved drug discount cards with or without the \$600 credit, free clinics, or drug discount websites.

What To Do If You **CURRENTLY DO NOT HAVE** **Prescription Drug Coverage**

Starting January 1, 2006, everyone with Medicare can get prescription drug coverage to help pay for their prescription drugs. This coverage is offered by private companies. If you have limited income and resources, see pages 55–62.

**Does your health care come from the
Original Medicare Plan with or
without a Medigap policy?**

- You can join a Medicare Prescription Drug Plan to add prescription drug coverage.

OR

**Does your health care come from a
Medicare Advantage Plan or other
Medicare Health Plan?**

- See page 46 for more information about your drug coverage choices.

Or

- You can join a Medicare Advantage Plan or other Medicare Health Plan in your area that provides health care coverage and covers prescription drugs.

See page 50 for more information if you don't have a Medigap policy.

See page 51 for more information if you have a Medigap policy.

Important: Prescription drug coverage is insurance. It's NOT doctor samples, discount cards, Medicare-approved drug discount cards with or without the \$600 credit, free clinics, or drug discount websites.

1. I have prescription drug coverage from a former or current employer or union. What do I need to know?

Medicare will help employers or unions continue to provide retiree drug coverage that meets Medicare's standards. Your (or your spouse's) former or current employer or union will send you information about how your current coverage compares to the Medicare standard prescription drug coverage by November 14, 2005. This information is important because it can affect the decision you will need to make this fall about if and when you sign up for Medicare prescription drug coverage.

Yes I Have
Drug Coverage



- If your (or your spouse's) employer or union has determined that your current coverage, **on average, is at least as good as** the Medicare standard prescription drug coverage (called **creditable prescription drug coverage**):
 - You can keep it as long as it is still offered by your employer or union; and
 - You won't have to pay a **penalty** if your employer or union stops offering prescription drug coverage as long as you join a Medicare drug plan within 63 days after the coverage ends—even if you join after May 15, 2006.

Example for someone with prescription drug coverage from a former employer

Regina is retired. She has prescription drug coverage from her previous employer. Her previous employer notifies her that her current coverage, on average, is at least as good as Medicare prescription drug coverage, and that Medicare will now help pay for the costs of that coverage. She reviews the information on her options provided by her previous employer, and she decides to keep her employer coverage. Because her current coverage is at least as good as Medicare prescription drug coverage, if she later (after May 15, 2006) decides to get Medicare prescription drug coverage, she won't have to pay a penalty. If her employer later stops offering prescription drug coverage, she should join a Medicare drug plan within 63 days after her current coverage ends to avoid paying the penalty.

Section 6: Medicare Prescription Drug Coverage

45

1. continued

- If your (or your spouse's) employer or union has determined that your current coverage, **on average, is not at least as good as standard Medicare prescription drug coverage**, if you want to join a drug plan, you must join by **May 15, 2006** to avoid a **penalty**.

Caution: If you drop your employer or union coverage, you may not be able to get it back. You also may not be able to drop your employer or union *drug coverage* without also dropping your employer or union *health coverage*.

If your employer or union drug coverage is not as good as Medicare prescription drug coverage, find out about your options from your benefits administrator. You may be able to

- Keep your current employer or union drug plan and join a Medicare drug plan to give you more complete prescription drug coverage.
- Only keep your current employer or union drug plan. But, if you join a Medicare drug plan after May 15, 2006, you will have to pay a **penalty**.
- Drop your current coverage and return to the Original Medicare Plan and join a Medicare Prescription Drug Plan, or join a Medicare Advantage Plan or other Medicare Health Plan that covers prescription drugs. See the caution above.

Example for someone with prescription drug coverage from a former employer

Juan is retired. He is in the Original Medicare Plan. He has prescription drug coverage from his former employer. His former employer notifies him that his current prescription drug coverage, on average, is not at least as good as standard Medicare prescription drug coverage. He reviews the information on his options provided by his former employer. He learns that his former employer now has a contract with a certain Medicare Prescription Drug Plan. He also learns that if he joins that plan, his employer will pay part of his Medicare prescription drug coverage monthly premium. Juan joins that Medicare Prescription Drug Plan and saves money on his prescription drugs, and his premium.

Visit
www.medicare.gov
on the web, or call
1-800-MEDICARE
(1-800-633-4227)
for a list of the
Medicare drug
plans in your area.

Section 6: Medicare Prescription Drug Coverage

2. I have a Medicare Advantage Plan (like an HMO, PPO, or PFFS Plan) or other Medicare Health Plan. What do I need to know?

Medicare is working with your Medicare Advantage Plan or other Medicare Health Plan to help them provide even more coverage or lower costs.

Yes I Have Drug Coverage



- If you currently have prescription drug coverage from your plan, you will get a notice from your Medicare Advantage Plan or other Medicare Health Plan about your prescription drug choices. Read any materials you get from your plan carefully.

No I Don't Have Drug Coverage



- If you don't have prescription drug coverage, and want to add it, you can
 - check with your current health plan to see if they will offer a prescription drug option in 2006. If they will, you will usually be required to get your drug coverage from your current health plan if you decide to stay in the plan, or
 - switch to another Medicare Advantage Plan or other Medicare Health Plan in your area that offers prescription drug coverage, or
 - switch to the Original Medicare Plan and join a Medicare Prescription Drug Plan (see page 53; see pages 66–67 about your Medigap policy rights).

Important: If you stay in your current plan that isn't offering drug coverage in 2006, you will have to pay a **penalty** if you want to switch to a plan that offers prescription drug coverage later.

Example for someone in a Medicare HMO

Esther has Medicare Part A and Part B and joined a Medicare HMO. She gets all her health care coverage from the plan, including some prescription drug coverage. Starting January 1, 2006, her Medicare HMO will provide her with new Medicare prescription drug coverage that is better than Medicare's standard. Although her premium will increase, she will now have more prescription drug coverage. She decides to stay with her HMO.

Note: If you are in some Medicare Advantage Plans (see page 35) or a Medicare Cost Plan (see page 36), you may have other options for how to get your prescription drug coverage.

If you have limited income and resources, you may qualify for help paying for Medicare prescription drug coverage (see pages 55–62).

Section 6: Medicare Prescription Drug Coverage

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Yes I Have
Drug Coverage



3. I have a Medigap (Medicare Supplement Insurance) policy that covers prescription drugs and I have the Original Medicare Plan (Medicare Part A and Part B). What do I need to know?

- Medigap policies are changing, see pages 25–26.
- This fall you will get a detailed notice in the mail from your Medigap insurance company describing your choices for prescription drug coverage. Read the notice carefully before making any decisions.
- To have Medicare help pay for your drugs, you must join a new plan that provides Medicare prescription drug coverage. This will reduce your premium costs because Medicare pays most of the premium for Medicare drug plans.
- You can first join a Medicare Prescription Drug Plan from November 15, 2005—May 15, 2006.
- Most prescription drug coverage offered by Medigap policies, on average, is **not** at least as good as Medicare prescription drug coverage. This means, in most cases, if you keep Medigap prescription coverage, and don't join a Medicare drug plan by May 15, 2006, you will have to pay a **penalty** if you choose to join later. Your next chance to join will be November 15—December 31 of each year. Your coverage would begin January 1 of the following year.
- Contact your Medigap insurance company before you make any changes to your prescription drug coverage.
- If you have your Medigap policy from a current or former employer or union, call your benefits administrator.

Example for someone with a Medigap policy that does covers prescription drugs

Ethel has a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage. She got a notice from her Medigap insurer that said her Medigap policy's drug coverage, on average, is not as good as Medicare prescription drug coverage. She decides to buy a Medigap policy offered by her Medigap company that doesn't have drug coverage. She joins a Medicare Prescription Drug Plan to save money. Since she joined before May 15, 2006, she doesn't have to pay a penalty. She now pays monthly premiums for her Medicare Part B, her Medicare Prescription Drug Plan, and her Medigap policy.

If you have limited income and resources, you may qualify for help paying for Medicare prescription drug coverage (see pages 55–62).



Section 6: Medicare Prescription Drug Coverage

Yes I Have
Drug Coverage



4. I get prescription drug coverage from TRICARE or the Department of Veteran's Affairs (VA), or the Federal Employee Health Benefits Program (FEHB). What do I need to know?

- As long as you still qualify, your TRICARE, VA, or FEHB prescription drug coverage is not changing.
- Contact your benefits administrator or your FEHB insurer for information about your TRICARE, VA, or FEHB coverage before making any changes. It will almost always be to your advantage to keep your current coverage without any changes.
- If you lose your TRICARE, VA, or FEHB coverage and you join a Medicare drug plan after May 15, 2006, in most cases, you won't have to pay a **penalty**, as long as you join within 63 days of losing TRICARE, VA, or FEHB coverage.

Example for someone with TRICARE

Sam retired from the military and he has TRICARE. His TRICARE plan pays for his prescription drugs. Sam decides not to change how he gets his health care because the prescription drug coverage offered through TRICARE is as good as Medicare prescription drug coverage.

Example for someone with Veteran's coverage

Douglas is a veteran. He gets his health care and prescription drugs from the Department of Veteran's Affairs (VA). Douglas decides not to change how he gets his health care because the prescription drug coverage offered through the VA is as good as Medicare prescription drug coverage.

Example for someone with FEHB

Mark retired from the Federal government. His FEHB plan pays for his prescription drugs. Mark decides to keep his current coverage because it is as good as Medicare prescription drug coverage.

If you have limited income and resources, you may qualify for help paying for Medicare prescription drug coverage (see Section 7).

Yes I Have
Drug Coverage



5. I have full coverage from my state Medicaid program. What do I need to know?

- Your Medicaid *prescription drug coverage* is changing. Medicare, not Medicaid, will start paying for your prescription drugs beginning January 1, 2006. Medicaid will still cover other care that Medicare doesn't cover.
- The last day that your state Medicaid program will pay for your prescription drugs is December 31, 2005.
- You will have continuous Medicare prescription drug coverage and, in most cases, will pay a small amount out of your own pocket. See page 58 for your costs.
- Medicare pays for almost all of the cost of your drugs if you join a Medicare Prescription Drug Plan or a Medicare Advantage Plan or other Medicare Health Plan with Medicare prescription drug coverage.
- Compare coverage and choose a plan. You can join a drug plan starting November 15, 2005.
- Medicare will let you know the plan it has picked for you in October 2005, but you can still compare plans and choose another plan by December 31, 2005. If you have not joined a drug plan by December 31, 2005, Medicare will enroll you in the plan it has picked to make sure that you don't miss a day of coverage. If you decide you want another plan, you can switch to another plan at any time without a *penalty*.
- If you have Medicare and full coverage from Medicaid, and live in an institution (like a nursing home), you will pay nothing for your covered prescription drugs.

Example for someone with full Medicaid coverage

Larry has full coverage from Medicaid. Larry received a letter telling him he could join a Medicare Prescription Drug Plan. Since he didn't join a plan, Medicare enrolled him in a Medicare Prescription Drug Plan in his area to make sure he wouldn't miss a day of coverage. Larry can look at other Medicare Prescription Drug Plans in his area. If he feels the Medicare Prescription Drug Plan he is in isn't meeting his needs, he can switch to another plan at any time.

Section 6: Medicare Prescription Drug Coverage

No I Don't Have
Drug Coverage

6. I only have the Original Medicare Plan (Medicare Part A and Part B), and I don't have prescription drug coverage. What do I need to know?

- To have Medicare help pay for your drugs, you must join a plan that provides Medicare prescription drug coverage. You can choose and join the plan that meets your needs. See page 54 to find out how to get more information.
- If you don't use a lot of prescription drugs now, you should still consider joining. As we age, most people need prescription drugs to stay healthy. For most people, joining now means that you will not have to pay a **penalty** if you choose to join later. Your premium will be higher if you wait to join after May 15, 2006 because of the penalty.
- You can first join a drug plan from November 15, 2005—May 15, 2006. In most cases, if you don't join during this period, your next chance to join will be November 15, 2006—December 31, 2006 and you will have to pay a penalty. This means you pay a higher premium for as long as you have Medicare prescription drug coverage.

Example for someone with the Original Medicare Plan

Mary is in the Original Medicare Plan. She doesn't have prescription drug coverage. She **pays for all of her prescriptions herself**. To help with her drug costs, Mary decides to join a Medicare Prescription Drug Plan. She looks at page 54 of her "Medicare & You" handbook to find out how to get more information. Mary has her daughter help her look at her choices on www.medicare.gov on the web. She chooses a plan that covers the drugs she is taking and includes the pharmacy she uses. She joins April 15, 2006 to avoid paying a penalty. Her coverage for prescription drugs begins May 1, 2006. Her Original Medicare Plan services continue without change.

If you have limited income and resources, you may qualify for help paying for Medicare prescription drug coverage (see pages 55–62).



7. I have a Medigap (Medicare Supplement Insurance) policy that doesn't cover prescription drugs and I have the Original Medicare Plan (Medicare Part A and Part B). What do I need to know?

No I Don't Have Drug Coverage



- To have Medicare help pay for your drugs, you must join a plan that provides Medicare prescription drug coverage. You can choose and join the plan that meets your needs. See page 54 to find out how to get more information.
- If you don't use a lot of prescription drugs now, you should still consider joining. As we age, most people need prescription drugs to stay healthy. For most people, joining now means that you will not have to pay a **penalty** if you choose to join later. Your premium would be higher if you wait to join after May 15, 2006 because of the penalty.
- You can first join a drug plan from November 15, 2005—May 15, 2006. In most cases, if you don't join during this period, your next chance to join will be November 15, 2006—December 31, 2006 and you may have to pay a penalty. This means you pay a higher premium for as long as you have Medicare prescription drug coverage.
- Contact your Medigap insurer for information about your policy. If you have your Medigap policy from a current or former employer or union, call your benefits administrator.

Example for someone with a Medigap policy that doesn't cover prescription drugs

Lillian has both the Original Medicare Plan (Medicare Part A and Part B) and a Medigap (Medicare Supplement Insurance) policy that doesn't cover prescription drugs. Lillian uses a few prescription drugs. She joins a Medicare Prescription Drug Plan to save money and limit future out-of-pocket costs for prescription drugs. Since she joined before May 15, 2006, she won't have to pay a penalty. She chooses a plan that covers the drugs she is taking and includes the pharmacy she uses. She will pay separate monthly premiums for her Medicare Part B, her Medigap policy, and her Medicare Prescription Drug Plan.

If you have limited income and resources, you may qualify for help paying for Medicare prescription drug coverage (see pages 55–62).

What do I need to think about before I decide to get Medicare prescription drug coverage?

Before you make a decision, you need to find out the following information.

- Do you have prescription drug coverage now? (Prescription drug coverage does NOT include doctor samples, discount cards, Medicare-approved drug discount cards with or without the \$600 credit, free clinics, or drug discount websites.)
- Does it cover at least as much as a Medicare Prescription Drug Plan? Your current plan can tell you if it does.
- How would Medicare prescription drug coverage affect your out-of-pocket costs? Keep in mind that Medicare prescription drug coverage also helps protect you against high out-of-pocket costs if your drug needs change.
- Should you keep the coverage you have?
- Does a Medicare drug plan in your area cover the drugs you need?
- Can you get extra help paying for your prescription drug costs if you join a Medicare drug plan (see pages 55–62)?
- If you wait to join a Medicare drug plan would your premium be higher because you have to pay a **penalty** (see page 40)? Would your coverage start when you wanted it to?
- Do you spend part of each year in another state? (This may be important if the plan requires you to use certain pharmacies.)

What are my costs if I decide to join a drug plan?

When you get Medicare prescription drug coverage, you pay part of the costs, and Medicare pays part of the costs. You pay a premium each month to join the drug plan. If you have Medicare Part B, you also pay your monthly Part B premium. If you belong to a Medicare Advantage Plan or Medicare Cost Plan, the monthly premium you pay to the plan may increase if you add prescription drug coverage.

Your costs will vary depending on which plan you choose. Your plan must, at a minimum, provide you with a standard level of coverage as shown below. Some plans offer more coverage or lower premiums. **You can get the actual costs of the Medicare Prescription Drug Plans, and the Medicare Advantage Plans or other Medicare Health Plans in your area by visiting www.medicare.gov the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**

Standard Coverage (the minimum coverage drug plans must provide)

If you join, in 2006, for covered drugs you will pay

- a **monthly premium** (varies depending on the plan you choose, but estimated at about \$37 in 2006).
- the first \$250 per year for your prescriptions. This is called your “**deductible**.”

After you pay the \$250 yearly deductible, **here's how the costs work:**

- You pay 25% of your yearly drug costs from \$250 to \$2,250, and your plan pays the other 75% of these costs, then
- You pay 100% of your next \$2,850 in drug costs, then
- You pay 5% of your drug costs (or a small **copayment**) for the rest of the calendar year after you have spent \$3,600 out-of-pocket. Your plan pays the rest.

Where can I get help choosing Medicare prescription drug coverage?

If you need help choosing Medicare prescription drug coverage that meets your needs, you can get personalized information by

- visiting www.medicare.gov on the web.
- calling 1-800-MEDICARE (1-800-633-4227). **TTY** users should call 1-877-486-2048. Have your Medicare card, a list of the drugs you use, and the name of the pharmacy you use ready when you call.
- getting a free copy of the booklet “Your Guide to Medicare Prescription Drug Coverage,” (CMS Pub. No. 11109), on www.medicare.gov, or by calling 1-800-MEDICARE.
- calling your State Health Insurance Assistance Program (see pages 86–88 for their telephone number).
- checking for local events for help enrolling. Contact your local office on aging. For the telephone number, visit www.eldercare.gov on the web.

Help for People with Limited Income and Resources



Section

There is extra help for people with limited income and resources to help pay for their health care and prescription drug costs.

You might qualify for one or more of the programs described in this section. This section covers the following seven programs:

1. Extra help paying for Medicare prescription drug coverage, see pages 56–58.
2. Medicaid (help from your state), see page 59.
3. Medicare Savings Programs (help from your state Medicaid program paying Medicare premiums), see page 60.
4. Supplemental Security Income benefits, see page 61.
5. The PACE Program (Programs of All-inclusive Care for the Elderly), see page 61.
6. Programs for People who live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, see page 62.
7. Medicare-approved Drug Discount Cards, see page 62.

These options are explained in the rest of this section. Your state or local area may have other programs that could help you. You should contact your State Medical Assistance office for more information (see page 85).

You may also want to look at pages 29–38 to find out about Medicare Advantage Plans and other Medicare Health Plans. These plans often provide more benefits and lower out-of-pocket costs. But, you may have to go to certain doctors and hospitals to get services.



Section 7: Help for People with Limited Income and Resources

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1.

Extra help paying for Medicare prescription drug coverage

What is this program?

If you have limited income and resources, you may qualify for extra help paying your prescription drug costs. If you qualify, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription copayments.

Note: The territories have their own rules for providing extra help to their residents. See page 62 for more information.

How do I qualify for this program?

The amount of extra help you receive will be based on your income and resources (including your savings and stocks, but not counting your home or car). You may qualify if your resources are less than \$11,500 if you are single or \$23,000 if you are married and living with your spouse.

Note: Amounts shown above are for 2005. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher.

What do I do next?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you didn't automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you didn't get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance office (see page 85). After you apply, you will receive a letter in the mail letting you know if you qualify or not and what you need to do next.

Section 7: Help for People with Limited Income and Resources



If you apply and qualify for extra help

You'll have to choose and join a Medicare Prescription Drug Plan by May 15, 2006, or Medicare will enroll you in a plan effective June 1, 2006 to make sure you get help paying for your prescription drug costs and you don't pay a penalty for late enrollment. If the plan Medicare chooses doesn't meet your needs, you can switch plans once before December 31, 2006. Generally, your next chance to switch is November 15—December 31 of each year. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for the plans that are available in your area.

Even if you have prescription drug coverage now, including through an employer or union, the Indian Health Service, or the Department of Veteran's Affairs, you should still apply for extra help. Check your current coverage to see how Medicare drug coverage with extra help will work with your current coverage.

Your Costs If You **Apply and Qualify** for Extra Help

If you have Medicare and you apply and qualify for extra help because your annual income is	Your monthly premium* for a standard plan is	Your yearly deductible is	Your cost per generic drug or certain drugs on formulary won't be more than	Your cost per other covered drug won't be more than
below \$12,920 (\$17,321 for a married couple living together) and your resources aren't more than \$7,500 (\$12,000 for a married couple living together)	\$0	\$0	\$2**	\$5**
below \$12,920 (\$17,321 for a married couple living together) and your resources are more than \$7,500 but aren't more than \$11,500 (\$12,000 but aren't more than \$23,000 for a married couple living together)	\$0	\$50	15% (each prescription)***	15% (each prescription)***
at or above \$12,920 but below \$14,355 (at or above \$17,321 but below \$19,245 for a married couple living together) and your resources aren't more than \$11,500 (\$23,000 for a married couple living together)	Discounted, but varies	\$50	15% (each prescription)***	15% (each prescription)***

Note: See footnotes for this table on bottom of page 58.

Section 7: Help for People with Limited Income and Resources

You automatically qualify for extra help and don't need to apply if you

- have Medicare and full coverage from a state Medicaid program that currently pays for your prescriptions. You should join a plan that meets your needs by December 31, 2005 because Medicaid will no longer pay for prescription drugs. If you don't, Medicare will enroll you in a plan effective January 1, 2006. You can switch plans at any time (see page 49), or
- get Supplemental Security Income, or get help from your state Medicaid program paying your Medicare premiums (belong to a Medicare Savings Program). You should join a plan that meets your needs by December 31, 2005. If you haven't signed up by May 15, 2006, Medicare will enroll you in a plan effective June 1, 2006. You can switch plans once before December 31, 2006.

Medicare mailed letters in May and June to people who automatically qualify for extra help.

Your Costs If You **Automatically Qualify** for Extra Help

If you have Medicare and you automatically qualify for extra help because	Your monthly premium* for a standard plan is	Your yearly deductible is	Your cost** for a generic drug or certain drugs on formulary won't be more than	Your cost** per other covered drug won't be more than
You have Medicaid and live in a nursing home or some other institution	\$0	\$0	\$0	\$0
You have Medicaid and your annual income is at or below \$9,570 (single) or \$12,830 (married)	\$0	\$0	\$1	\$3
You have Medicaid and your annual income is above \$9,570 (single) or \$12,830 (married)	\$0	\$0	\$2	\$5
Your state helps you pay for your Medicare premiums	\$0	\$0	\$2	\$5
You get Supplemental Security Income (SSI) but not Medicaid	\$0	\$0	\$2	\$5

Note: Income levels are for 2005, resource and cost-sharing amounts are for 2006, and will increase each year. The size of your family can also affect whether you qualify based on income. If you live in Alaska or Hawaii, income levels are higher.

* If you join a plan that has a premium higher than a standard plan, you will have to pay the difference (for example, if a standard plan costs \$37 per month, and you join a plan that costs \$40 per month, you will have to pay the \$3 difference each month).

The amounts decrease to ** \$0 per prescription or *** \$2 and \$5 per prescription once the amount you pay and Medicare pays as the extra help reach \$3,600 per year.

2.

Medicaid

What is this program?

Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources. Most of your health care costs are covered if you have Medicare and Medicaid.

Medicaid programs vary from state to state. People with Medicaid may get coverage for services such as nursing home and home health care, that aren't fully covered by Medicare.

How do I qualify for this program?

The income limits for Medicaid vary from state to state. You need to contact your State Medical Assistance office to see if you qualify.

What do I do next?

For more information about Medicaid, call your State Medical Assistance office. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state.



Section 7: Help for People with Limited Income and Resources

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3.

Medicare Savings Programs (help from your state Medicaid program paying Medicare premiums)

What is this program?

States have programs for people with limited income and resources that pay Medicare **premiums** and, in some cases, may also pay Medicare **deductibles** and **coinsurance**. These programs help millions of people with Medicare save money each year.

How do I qualify for this program?

- You must have Medicare Part A. (If you are paying a premium for Medicare Part A, the Medicare Savings Program may pay the Medicare Part A premium for you.)
- You must be an individual with **resources** of \$4,000 or less, or a married couple with resources of \$6,000 or less. Resources include things like money in a checking or savings account, stocks, and bonds.
- You must be an individual with a monthly **income** of less than \$1,097, or a married couple with a monthly income of less than \$1,464. Income limits will change slightly in 2006. If you live in Alaska or Hawaii, income limits are slightly higher.

Note: Individual states may have more generous income and/or resource requirements.

What do I do next?

Call your State Medical Assistance office. Since the names of these programs may vary by state, ask for information on Medicare Savings Programs. It's very important to call if you think you qualify for any of these Medicare Savings Programs, even if you aren't sure. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state.

Section 7: Help for People with Limited Income and Resources



4.

Supplemental Security Income Benefits

What is this program?

Supplemental Security Income (SSI) is a monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren't the same as Social Security benefits. You can make an appointment to apply for SSI benefits on the telephone or in person at your local Social Security office.

How do I qualify for this program?

To qualify for SSI, you must have limited income and resources, and be disabled, blind, or age 65 or older. You also must be a resident of the United States, not be absent from the country for more than 30 days, and be either a U.S. citizen or national, or in one of certain categories of eligible non-citizens.

What do I do next?

For more information, call Social Security at 1-800-772-1213, or contact your local Social Security office. **TTY** users should call 1-800-325-0778. You can also visit www.socialsecurity.gov and use the Benefits Eligibility Screening Tool (BEST) to find out if you are eligible for SSI or other benefits to help you decide whether to apply.

5.

The PACE Program (Programs of All-inclusive Care for the Elderly)

What is this program?

PACE combines medical, social, and long-term care services for frail people. Some PACE programs may also provide Medicare prescription drug coverage. PACE might be a better choice for you instead of getting care through a nursing home. PACE is available only in states that have chosen to offer it under **Medicaid**.

How do I qualify for this program?

The qualifications for PACE vary from state to state. You need to contact your State Medical Assistance office to see if you qualify.

What do I do next?

To find out if you are eligible and if there is a PACE site near you, or for more information, call your State Medical Assistance office (see page 85).

You can also visit www.cms.hhs.gov/pace/pacesite.asp on the web for PACE locations and telephone numbers.

Section 7: Help for People with Limited Income and Resources

6.

Programs for People who live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa

What is this program?

There are programs for people with limited income and resources who live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

How do I qualify for this program?

Programs vary in these areas.

What do I do next?

To find out more about their rules call your State Medical Assistance office (see page 85), visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

7.

Medicare-approved Drug Discount Cards

What is this program?

Medicare-approved drug discount cards were introduced in 2004 to help people with Medicare get a discount on their prescription drugs, until the new Medicare prescription drug coverage starts in 2006. The drug discount cards are temporary and Medicare-approved drug discount cards end in 2006. You can continue to use your drug discount card until May 15, 2006, or until you join a drug plan, whichever comes first.

What if I qualified for the credit on my Medicare-approved drug discount card?

If you qualified for the credit for your Medicare-approved drug discount card, you can continue to use the remainder of your credit until May 15, 2006, or until you join a drug plan, whichever comes first. If you qualified for the credit, you may also qualify for help paying your drug plan costs (see pages 56–58).

What do I do next?

To find out more about Medicare-approved drug discount cards and the credit, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.



Section

Sometimes, people with Medicare decide to join a plan or switch to another plan. For example, a person who has the Original Medicare Plan might decide to switch to a Medicare HMO. Or, a person who has a Medicare PPO might decide to switch to the Original Medicare Plan. This section gives you information about joining a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, or switching to another plan.

For information about joining the Original Medicare Plan, see Section 4.

Who can join a Medicare Advantage Plan or other Medicare Health Plan?

You can generally join if

- you live in the service area of the plan you want to join. The service area is where you must live for the plan to accept you as its member. In the case of a Medicare HMO, it's also usually where you get services from the plan. The plan can give you more information about its service area.
- you have Medicare Part A **and** Part B (except for Medicare Cost Plans where you may join one with only Part B). However, if you are already in a Medicare Health Plan and have only Part B, you may stay in your plan.
- you don't have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant), except as explained on page 66.

If you have prescription drug coverage from a former or current employer or union, contact your benefits administrator before you make any changes to your drug coverage.

Section 8: Joining and Switching Plans

Who can join a Medicare Prescription Drug Plan?

Everyone with the Original Medicare Plan, a Medicare Private Fee-for-Service Plan that doesn't offer prescription drug coverage, or a Medicare Cost Plan can join a Medicare Prescription Drug Plan in their area.

Caution: Generally, you can only join one plan at a time. **If you currently have a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan and you enroll in another Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, you will be disenrolled from the plan you have today when your enrollment in the new plan begins.** People in some Medicare Private Fee-for-Service Plans and people in Medicare Cost Plans may also join a Medicare Prescription Drug Plan and be in both plans at the same time.

When can I join one of these plans?

You can join any Medicare Advantage Plan or other Medicare Health Plan, or Medicare Prescription Drug Plan available in your area

1. when you first become eligible for Medicare, during the period that starts three months before the month you turn age 65 and ends three months after the month you turn age 65. If you get Medicare due to a disability, you can join three months before and after your 24th month of cash disability benefits.
2. between November 15, 2005 and May 15, 2006, if you currently have Medicare. If you join by December 31, 2005, your Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan coverage will begin on January 1, 2006. If you wait until after December 31, 2005 to join, your coverage will be effective the first day of the month after the month you join. If you don't join by May 15, 2006, you will have to wait until November 15, 2006 to join. Enrollment is generally for the calendar year.

Note: In special circumstances, you may be able to join a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan at other times. For instance, if you already have a Medicare Advantage Plan and you move, you can join a Medicare Advantage Plan that is offered in your new area.

Special Rule in 2006 for Joining Medicare Advantage or other Medicare Health Plans: In 2006, you have until June 30, 2006 to join a Medicare Advantage Plan or other Medicare Health Plan. However, if you already have a Medicare Advantage Plan or other Medicare Health Plan with prescription drug coverage but want to switch plans, and don't switch plans until between May 15 and June 30, 2006 you can only switch to another Medicare Advantage Plan or other Medicare Health Plan that offers drug coverage. Likewise, if you have a plan without prescription drug coverage but want to switch plans, you can only join a plan that doesn't include drug coverage.

Special Note for Joining Medicare Prescription Drug Plans: If you don't join a Medicare Prescription Drug Plan by May 15, 2006, and you don't currently have drug coverage that covers on average, at least as much as a Medicare Prescription Drug Plan, your premium cost will go up at least 1% per month for every month that you wait to enroll that you don't have coverage at least as good as standard Medicare prescription drug coverage. You will have to pay this **penalty** as long as you have Medicare prescription drug coverage.

Special Note if you have limited income and resources: If you receive full Medicaid coverage from your state, you can join or switch a plan at any time. If you apply and qualify for extra help, and don't join a plan by May 15, 2006, Medicare will enroll you in a plan. If the plan Medicare chooses doesn't meet your needs, you can switch plans once before December 31, 2006. Generally, your next chance to switch is November 15—December 31 of each year.

How do I join a Medicare Advantage Plan or other Medicare Health Plan, or Medicare Prescription Drug Plan?

Compare the Medicare Advantage Plans, other Medicare Health Plans, and Medicare Prescription Drug Plans available in your area. Once you have decided which plan you want, contact the plan you are interested in for enrollment information. For example, some plans will send you an enrollment form. Fill out the form and mail it to the plan, or give it to the plan representative. You can get help filling out this form. You will get a letter from the plan telling you when your coverage begins.

Caution: You can't call a Medicare Advantage Plan or other Medicare Health Plan to join over the telephone, unless you are switching to another plan offered by the same company, and the company offers that option. Also, if you join a Medicare Prescription Drug Plan using the web, the plan must send you a bill. The plan can't ask for payment at the time you join.

Section 8: Joining and Switching Plans

Special Rules for People with End-Stage Renal Disease

If you have End-Stage Renal Disease (ESRD) and you are in the Original Medicare Plan, you may join a Medicare Prescription Drug Plan, but you usually can't join a Medicare Advantage Plan or other Medicare Health Plan. However, if you are already in such a plan, you can stay in it or join another plan offered by the same company in the same state. If you've had a successful kidney transplant, you may be able to join a Medicare Advantage Plan or other Medicare Health Plan. Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease, and Medicare Advantage Plans and other Medicare Health Plans. **TTY** users should call 1-877-486-2048.

If you have ESRD and are in a Medicare Advantage Plan or other Medicare Health Plan and the plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan or other Medicare Health Plan. You don't have to use your one-time right to join a new plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan or other Medicare Health Plan at a later date as long as the plan is accepting new members.

You may also be able to join a Medicare [Special Needs Plan](#) for people with ESRD if one is available in your area.

Can I keep my Medigap (Medicare Supplement Insurance) policy if I join a Medicare Advantage Plan or other Medicare Health Plan ?

Yes, you can keep it. However, **you will have to keep paying your premiums and you may get little or no benefit from it while you are in a Medicare Advantage Plan or other Medicare Health Plan.** If you join a Medicare Advantage Plan or other Medicare Health Plan, you will have to pay copayments and deductibles. Also, if your plan covers prescription drugs and you have a [Medigap policy](#) that covers prescription drugs, the drug coverage must be removed from the Medigap policy, and the premium changed. You can call your State Health Insurance Assistance Program if you need help deciding whether to keep your Medigap policy (see pages 86–88 for their telephone number).

If you drop your [Medigap policy](#), you may not be able to get it back, except in certain situations. If you join a Medicare Advantage Plan or other Medicare Health Plan when you first become eligible for Medicare at age 65, or if this is the first time you've joined a Medicare Advantage Plan or other Medicare Health Plan, or a Medicare SELECT policy, you may have special Medigap protections that give you a right to get your old Medigap policy back or buy a new one later if you choose to leave your plan within the first year. At that time, you may also be able to join a Medicare Prescription Drug Plan.

For more information on Medigap policies and protections, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and get a free copy of "Choosing a Medigap Policy: A Guide to Health Insurance For People With Medicare" (CMS Pub. No. 02110).

Can I join a Medicare Advantage Plan or other Medicare Health Plan if I have employer or union coverage?

If you join a Medicare Advantage Plan or other Medicare Health Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your plan coverage. Talk to your employer or union benefits administrator about the rules that apply. Remember, if you drop your employer or union coverage, you may not be able to rejoin it later.

Switching a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan

When can I switch my plan?

Generally, if you join a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, you can only change plans under certain circumstances. **You can choose to switch your current plan from November 15 through December 31 of every year.** Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can switch your plan at other times. After you request to switch, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

Section 8: Joining and Switching Plans

Note: Members of Medicare Advantage Plans or other Medicare Health Plans have another chance to switch plans until June 30, 2006.

How do I switch my plan?

You can switch your Medicare plan in one of three ways:

1. Join another Medicare plan
2. Write or call your plan
3. Call 1-800-MEDICARE (1-800-633-4227)

If you want to switch from a Medicare Advantage Plan or other Medicare Health Plan to the Original Medicare Plan and buy a Medigap policy, you need to contact your current plan or call 1-800-MEDICARE (1-800-633-4227). Simply signing up for the Medigap policy won't end your Medicare Advantage Plan or other Medicare Health Plan coverage. After January 1, 2006, you won't be able to buy a Medigap policy that includes prescription drug coverage. In some cases, you may not be able to buy any Medigap policy.

If you want to talk to someone who can help you decide if this is right for you, call your [State Health Insurance Assistance Program](#).

You can find the telephone number for your state on pages 86–88.

If you want to switch from a Medicare Advantage Plan or other Medicare Health Plan to join a new Medicare Advantage Plan or other Medicare Health Plan, by June 30, 2006, simply join in the new plan that you have chosen. You don't need to tell your old plan you are leaving or send them anything. You will be disenrolled automatically from your old plan when your new plan coverage begins. You should get a letter from your new plan telling you when your coverage starts.

What if I move out of the plan's service area?

You may have to switch to another plan. However, you can call the plan to see if you can stay in the plan. If you must switch to another plan, follow the instructions on page 68 for switching a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan. You can choose to join another Medicare Advantage Plan or other Medicare Health Plan if one is available in your new area, or join another Medicare Prescription Drug Plan. You can join the Original Medicare Plan, because you moved out of the plan service area and you will then have the right to buy a [Medigap policy](#) (see pages 25–26). Remember, no new Medigap policies with prescription drug coverage can be sold after January 1, 2006.

What can I do if my plan leaves the Medicare Program?

At the end of the year, your plan may decide to leave the Medicare Program. If your plan leaves the Medicare Program, the plan will send you a letter to notify you. The letter will tell you about your options.

Special Rules if you are in a Medicare Advantage Plan or other Medicare Health Plan that leaves the Medicare Program. You will be automatically returned to the Original Medicare Plan if you don't choose to join another Medicare Advantage Plan or other Medicare Health Plan. You will have the right to buy a Medigap policy (see pages 25–26). In this case, you should learn as much as you can about your choices before making a decision. No matter what you choose, you are still in the Medicare Program and will get all Medicare-covered services.

If your plan covers prescription drugs and you want to keep getting prescription drug coverage, you need to join another plan that offers this coverage. If you decide to return to the Original Medicare Plan and want to continue to have drug coverage, you will have to join a Medicare Prescription Drug Plan.

Section 8: Joining and Switching Plans

What can I do if I have to leave my Medicare Advantage Plan or other Medicare Health Plan because my plan reduces its service area?

At the end of the year, your plan may decide not to provide services in all counties or ZIP codes in an area. If your plan reduces its service area and there are no other plans in your area, you may be able to keep your coverage with that plan. Ask your plan. If your plan offers this option, you must agree to travel to the plan's service area to get all your services (except for emergency and urgently needed care). If your plan doesn't offer this option, you will automatically return to the Original Medicare Plan on January 1. In this case, you will have the right to buy a [Medigap policy](#) (see pages 25–26). Remember, no new Medigap policies with prescription drug coverage can be sold after January 1, 2006.

Other Insurance and Ways to Pay Health Care Costs

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Section

Now is a good time to review all your health care coverage. In addition to Medicare, you may already have or be eligible for other health care coverage such as employer or retiree coverage. You also might be able to lower your out-of-pocket costs by buying other supplemental health coverage.

The coverage you have will affect how much you pay, what benefits you may have, which doctors you can see, and other things that may be important to you. Other insurance and ways to pay health care costs include

1. Employer and Union health coverage, see page 72.
2. Veteran's Benefits, see page 73.
3. Military Retiree Benefits (TRICARE), see page 73.
4. Federal Employee Health Benefits Program (FEHB), see page 73.
5. Paying for Long-Term Care, see page 74.

For more information about how other kinds of insurance work with Medicare, visit www.medicare.gov on the web, call your **State Health Insurance Assistance Program** (see pages 86–88 for their telephone number), or call 1-800-MEDICARE (1-800-633-4227) to get a free copy of “Medicare and Other Health Benefits: Your Guide to Who Pays First” (CMS Pub. No. 02179).

Remember,
blue words in
the text are
defined on
pages 89–92.

Section 9: Other Insurance and Ways to Pay Health Care Costs

1.

Employer or Union Health Coverage

Call the benefits administrator at your, your spouse's, or other family member's current or former employer or union. Ask if you have or can get health care coverage based on your, your spouse's, or other family member's past or current employment. When you have coverage from an employer or union, this coverage is voluntary. The employer or union generally has the right to change benefits and premiums, or stop offering coverage.

Medicare will help employers or unions continue to provide retiree drug coverage that meets Medicare's standard. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you how your drug plan will work with the new Medicare Prescription Drug Plans. In some cases, if you join a Medicare Prescription Drug Plan, it can limit or end your employer or union coverage. Before you join a Medicare Prescription Drug Plan, call your employer's or union's benefits administrator. For more information, see pages 44–45.

Caution: If you drop your employer or union group health coverage, you may not be able to rejoin it later. You also may not be able to drop *drug* coverage without also dropping all of your *health* coverage.

For more information, call your employer's or union's benefits administrator.

Note about COBRA

If you are eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) because you have stopped working or because you qualify for other reasons, you should consider enrolling in Medicare Part B and/or a Medicare Prescription Drug Plan. You won't get a Special Enrollment Period when your COBRA coverage ends, and you may have to pay more for Part B and/or a Medicare Prescription Drug Plan if you join later. Before you elect COBRA coverage, it may be helpful to talk with your State Health Insurance Assistance Program about whether buying a Medigap policy would be better for you than electing COBRA coverage. See the inside back cover for their telephone number.

2.

Veterans' Benefits

If you are a veteran or have had any U.S. military service, call the U.S. Department of Veteran's Affairs at 1-800-827-1000 or visit www.va.gov on the web for information about veterans' benefits and services available in your area. Depending on how close you live to a VA facility, you may be able to get your prescription drugs through the VA program.

3.

Military Retiree Benefits (TRICARE)

TRICARE is a health care program for active duty and retired uniformed services members and their families. It includes TRICARE Prime, TRICARE Extra, and TRICARE Standard. Medicare-eligible uniformed services retirees age 65 or older, and certain family members have access to expanded medical coverage known as TRICARE for Life (TFL). You must have Medicare Part A and Part B to get TFL benefits.

In general, Medicare pays first for Medicare-covered services. If Medicare doesn't pay all of the bill, TRICARE might pay some of the costs as the second payer. TRICARE will also pay the Medicare deductible and coinsurance amounts, and for any services not covered by the Original Medicare Plan that TRICARE covers. TRICARE also covers prescription drugs.

For more information about the TRICARE programs, call 1-888-363-5433 or visit www.tricare.osd.mil on the web.

4.

Federal Employee Health Benefits Program (FEHB)

The FEHB Program offers health coverage for current and retired Federal employees and covered family members. Generally, plans under the FEHB Program help pay for the same kind of expenses as Medicare. FEHB plans also provide coverage for prescription drugs, routine physicals, emergency care outside of the United States and some preventive services that Medicare doesn't cover. Some FEHB plans also provide coverage for dental and vision care.

If you are covered under the FEHB Program, you will get information during the open season about your prescription drug coverage. Read this information carefully. Contact the Office of Personnel Management if you have additional questions.

Section 9: Other Insurance and Ways to Pay Health Care Costs

5.

Paying for Long-Term Care

Long-term care can be very expensive. Since Medicare generally doesn't cover this care, it's very important to plan ahead before a crisis occurs. You should think about how to get and pay for long-term care services before you need that type of care. Some options you may want to consider are explained below.

A. Long-Term Care Insurance

Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs, such as bathing, dressing, using the bathroom, and eating.

For more information about long-term care insurance, get a copy of "A Shopper's Guide to Long-Term Care Insurance" from either your State Insurance Department (call 1-800-MEDICARE to get the telephone number for your State Insurance Department), or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Or, call your State Health Insurance Assistance Program (see pages 86–88 for their telephone number).

Important: If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your state. If you aren't sure, call your State Insurance Department.

B. Reverse Mortgages

An option for homeowners is a "reverse mortgage." It allows some people to use the equity they have in their home as a source of income, without losing ownership. It is a type of loan. Talk to a lawyer or financial advisor about the benefits and risks of a reverse mortgage. You can also look at www.medicare.gov on the web for more information. Select "Search Tools" at the top of the page.

C. Life Insurance

Some insurance companies let you use your life insurance policy to pay for long-term care. Ask your insurance agent how this works.

D. Personal Resources

You can use your savings to pay for long-term care. Once you have spent most of your resources, you may qualify for Medicaid (see page 59).

For more information about long-term care, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), to get a free copy of "Choosing Long-Term Care: A Guide for People with Medicare" (CMS Pub. No. 02223).

Your Medicare Rights



Section

Your Right to Appeal Denied Services

If you have Medicare, you have certain guaranteed rights. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. **No matter what kind of Medicare plan you have, you always have the right to appeal.** Some of the reasons you may appeal include

- a service or item you received isn't covered, and you think it should be.
- a service or item is denied, and you think it should be paid.
- you question the amount that Medicare paid.

Information on how to file an appeal is on the Medicare Summary Notice (if you are in the [Original Medicare Plan](#)), in your health plan materials (if you are in a [Medicare Advantage Plan](#) or other [Medicare Health Plan](#)), or in your drug plan materials (if you are in a [Medicare Prescription Drug Plan](#)). If you decide to file an appeal, ask your doctor or provider for any information that may help your case.

If you are in the Original Medicare Plan, you are protected from unexpected bills. A doctor or supplier may give you a notice that says Medicare probably (or certainly) won't pay for a service. If you still want to get the service, you will be asked to sign an agreement that you will pay for the service yourself if Medicare doesn't pay for it. This is called an Advance Beneficiary Notice. Advance Beneficiary Notices are used in the Original Medicare Plan. Medicare Advantage Plans, other Medicare Health Plans, and Medicare Prescription Drug Plans have other ways of providing this information.

If you aren't sure if Medicare was billed for the services that you got, write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from that provider. You should get it within 30 days.

Also, you can check your Medicare Summary Notice to see if the service was billed to Medicare. If the service was not billed to Medicare you can request a "Demand Bill."

If you are in a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, call your plan to find out if a service or item will be covered. The plan must tell you if you ask.

Remember,
blue words in
the text are
defined on
pages 89–92.

Section 10: Your Medicare Rights

Fast-Track Appeals

If you are enrolled in the Original Medicare Plan, you have the right to a fast appeal when your provider services are ending. This fast appeal is called an expedited review. You can get an expedited review whenever you are discharged (or services are stopped) from an inpatient hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice. You will get a notice from your provider that will tell you how to ask for an appeal if you believe that your services are ending too soon. You will be able to get an expedited review of this decision, with independent doctors looking at your case to decide if your services need to continue. If you decide to file an appeal, ask your doctor for any information that may help your case. You may have other appeal rights if you miss the timeframe for filing a fast-track appeal.

If you are enrolled in a Medicare Advantage Plan or other [Medicare Health Plan](#), you have the right to a fast-track appeals process. You can get a quick review whenever you are discharged (or services are stopped) from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility, or getting inpatient hospital care. You will get a notice from your provider or plan that will tell you how to ask for an appeal if you believe that your services are ending too soon. You will be able to obtain a **quick review** of this decision, with independent doctors looking at your case and deciding if your services need to continue. You may have other appeal rights if you miss the timeframe for filing a fast-track appeal.

Can I appeal my Medicare Prescription Drug Plan's decisions?

Yes. You have the right to get a written explanation from your Medicare Prescription Drug Plan. Some reasons you might ask for a written explanation are if the pharmacist tells you that your drug plan won't cover a prescription or you are asked to pay more than you think you are required to pay. You also have the right to ask your drug plan for an exception if you and your doctor believe you need a drug that isn't on your drug plan's list of covered drugs.

If you disagree with the information provided by a pharmacist, you can contact your drug plan to ask for a coverage determination. The pharmacy will give you or show you a notice that explains how to contact your drug plan. Once your drug plan receives your request for a coverage determination, the drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to make a decision. If you disagree with that decision, you will have the right to appeal.

You must request the appeal within 60 calendar days from the date of the decision. A standard request must be made in writing unless your plan accepts requests by phone. You can call your plan or write to them for an expedited request. Once your plan receives your request for an appeal, the plan has seven days (for a standard request for coverage or to pay you back) or 72 hours (for an expedited request for coverage) to make its decision.

When you enroll in a Medicare Prescription Drug Plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and call your plan if you have questions.

For more information about your appeal rights, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and say "Publications" to get a free copy of "Your Guide to Medicare Prescription Drug Coverage" (CMS Pub. No. 11109).

Other Medicare Rights

In addition, you have rights to

- get information
- get emergency room services
- see doctors; specialists, including women's health specialists; and go to Medicare-certified hospitals
- participate in treatment decisions
- know your treatment choices
- get information in a culturally competent manner in certain circumstances (for example, get information in languages other than English from Medicare, and its providers and contractors)
- file complaints
- nondiscrimination
- have your personal and health information kept private

For more information about your rights and protections, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), and say "Publications" to get a free copy of "Your Medicare Rights and Protections" (CMS Pub. No. 10112).

Section 10: Your Medicare Rights

Notice of Privacy Practices for the Original Medicare Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out ("disclose") your personal medical information held by Medicare.

Medicare must use and give out your personal medical information to provide information

- to you or someone who has the legal right to act for you (your personal representative),
- to the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- where required by law.

Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare Program. For example:

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

Medicare may use or give out your personal medical information for the following purposes under limited circumstances

- to State and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs),
- for public health activities (such as reporting disease outbreaks),
- for government health care oversight activities (such as fraud and abuse investigations),
- for judicial and administrative proceedings (such as in response to a court order),
- for law enforcement purposes (such as providing limited information to locate a missing person),
- for research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),
- to avoid a serious and imminent threat to health or safety,
- to contact you about new or changed benefits under Medicare, and
- to create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an “authorization”) to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back (“revoke”) your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

- see and get a copy of your personal medical information held by Medicare.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.
- get a listing of those getting your personal medical information from Medicare. The listing won’t cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.
- ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request.
- get a separate paper copy of this notice.

Visit www.medicare.gov on the web for more information on

- exercising your rights set out in this notice.
- filing a complaint, if you believe the [Original Medicare Plan](#) has violated these privacy rights. Filing a complaint won’t affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a customer service representative about Medicare’s privacy notice. TTY users should call 1-877-486-2048.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa on the web or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

The Notice of Privacy Practices for the Original Medicare Plan became effective April 14, 2003.

Section 10: Your Medicare Rights

You Can Help Protect Yourself and Medicare from Billing Fraud

Most doctors, health care providers, plans, and pharmacies who work with Medicare are honest. There are a few who aren't honest. Medicare is working very hard with other government agencies to protect you and the Medicare Program.

Medicare fraud happens when Medicare is billed for services you never got. Medicare fraud takes a lot of money every year from the Medicare Program. You pay for it with higher premiums. A fraud scheme can be carried out by individuals, companies, or groups of individuals.

If you suspect billing fraud, you can

1. Call your health care provider to be sure the billing is correct, or
2. Call 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048), or
3. Call the Inspector General's hotline 1-800-HHS-TIPS (1-800-447-8477).

When you get health care in the **Original Medicare Plan**, you get a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid. You should check the notice for mistakes. Make sure that Medicare wasn't charged for any services or supplies that you didn't get. If you see a charge on your bill that may be wrong, call the health care provider and ask about it. The bill may be correct, and the person you speak to may help you to better understand the services or supplies you got. Or, you may have discovered an error in billing that needs to be corrected. If you aren't satisfied after speaking with your provider, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You Are Protected from Discrimination

Every company or agency that works with Medicare must obey the law. You can't be treated differently because of your race, color, national origin, disability, age, religion, or sex under certain conditions. Also, your rights to health information privacy are protected. If you think that you haven't been treated fairly for any of these reasons, call the Office for Civil Rights in your state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

For More Information



Section

www.medicare.gov on the web

Go to the official Medicare website for quick answers and information.

Here are some things you can do on the website:

- ★ **Find a Medicare Prescription Drug Plan**
- ★ **Compare health plan options in your area**
- ★ **Find a doctor**
- ★ **Find out if you are eligible for Medicare and when you can enroll**
- ★ **Find out what Medicare covers**
- ★ **Get information on the quality of care provided by nursing homes, hospitals, home health agencies and dialysis facilities**

NEW



My.Medicare.gov

My.Medicare.gov provides you with direct Internet access to your Medicare benefits, eligibility, and preventive health information—24 hours a day, 7 days a week. Visit the site, sign up, and Medicare will mail you a password to allow you access to your personal Medicare information. Later in 2006, My.Medicare.gov will also include access to information on your Medicare claims. (This feature is already available to residents of Indiana.)

Section 11: For More Information

1-800-MEDICARE Helpline

At Medicare, we are always working to improve our service to you. The 1-800-MEDICARE (1-800-633-4227) helpline has replaced the touch-tone system with a speech-automated system to make it easier for you to get the information you need 24 hours a day, including weekends.

The system will ask you questions that you answer with your voice to direct your call automatically.

Remember to

- speak clearly,
- call from a quiet area, and
- have your red, white, and blue Medicare card in front of you.

You can get to the right customer service representative faster if you use the chart below to direct your call. If you need help at any time, you can always say “Agent.”

If you are calling about...

Just say...

Medicare prescription drug coverage	“Drug Coverage”
Doctor’s bills, x-rays, or outpatient doctor’s care	“Doctor’s Service”
Inpatient or outpatient hospital visit or emergency room care	“Hospital Stay”
Oxygen, wheelchairs, walkers, eyeglasses, diabetic supplies, or Medicare-covered prescription drugs	“Medical Supplies”
Plan choices under Medicare, including Medicare Advantage	“Plan Choices”
Ordering Medicare publications (including the ones listed in this handbook)	“Publications”

TTY users should call 1-877-486-2048.

Medicare Publications

Below is a list of detailed booklets covering some of the topics discussed in this handbook. Booklets on other topics are also available. Many of these booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). To get copies of these free booklets or to see what's available, visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. You can also call 1-800-MEDICARE (1-800-633-4227) and say "Publications" for a free copy. TTY users should call 1-877-486-2048.

Information about the Original Medicare Plan

- "Your Medicare Benefits" (CMS Pub. No. 10116)
- "Enrolling in Medicare" (CMS Pub. No. 11036)
- "Guide to Medicare's Preventive Services" (CMS Pub. No. 10110)
- "Your Medicare Rights and Protections" (CMS Pub. No. 10112)
- "Choosing a Medigap Policy: A Guide to Health Insurance For People With Medicare" (CMS Pub. No. 02110)

Information about Medicare Advantage Plans and Other Medicare Health Plans

- "Choosing a Medicare Health Plan: A Guide for People with Medicare" (CMS Pub. No. 02219)
- "Quick Facts About Medicare's New Coverage for Prescription Drugs for people with a Medicare Health Plan, with prescription drug coverage" (CMS Pub. No. 11135)
- "The Facts About Medicare Advantage" (CMS Pub. No. 11061)

Information about Medicare Prescription Drug Coverage

- "Your Guide to Medicare Prescription Drug Coverage" (CMS Pub. No. 11109)
- "Introducing Medicare's New Coverage for Prescription Drugs" (CMS Pub. No. 11103)
- "The Facts about Medicare Prescription Drug Plans" (CMS Pub. No. 11065)
- "Quick Facts about Medicare's New Coverage for Prescription Drugs" (CMS Pub. No. 11102)

Section 11: For More Information

Other Important Contacts

Telephone numbers for important contacts are listed for organizations that provide nationwide services. These numbers were correct at the time of printing. Sometimes these numbers change. To get the most up-to-date telephone numbers, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227).

1-800-MEDICARE Helpline (see page 82)	1-800-633-4227 TTY 1-877-486-2048
Social Security Administration Call for address or name changes, death notification, enrolling in Medicare, to replace your Medicare card, and about Social Security benefits.	1-800-772-1213 TTY 1-800-325-0778
Coordination of Benefits Contractor	1-800-999-1118 TTY 1-800-318-8782
Department of Defense/TRICARE	1-888-363-5433
Department of Health and Human Services, Office of the Inspector General	1-800-447-8477 TTY 1-800-377-4950
Office for Civil Rights	1-800-368-1019 TTY 1-800-537-7697
Department of Veteran’s Affairs	1-800-827-1000 TTY 1-800-829-4833
Railroad Retirement Board (RRB beneficiaries only)	Local RRB office or 1-800-808-0772
State Health Insurance Assistance Program	See pages 86–88

For these local organizations, you can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state.

State Insurance Department—

Call with general insurance questions.

State Medical Assistance Office —

Call with questions about programs (including Medicaid) to help people with limited incomes and resources pay medical bills.

Quality Improvement Organization—

Call with complaints about the quality of Medicare-covered services.

Call 1-800-MEDICARE to be connected with the following organization in your state.

Say “Medical Supplies” to be connected to your Durable Medicare Equipment Regional Carrier—

Call with questions about durable medical equipment like prosthetics, orthotics, and other supplies.

Say “Doctor’s Services” to be connected to your Medicare Carrier—

Call with questions about Medicare Part B (Medical Insurance) services and bills. (Railroad Retirement beneficiaries should call 1-800-833-4455).

Say “Nursing Home,” “Home Health Care,” or “Hospice Facility” to be connected to your Regional Home Health Intermediary—

Call with questions about home health bills.

TTY users should call 1-877-486-2048.

Section 11: For More Information

State Health Insurance Assistance Program: For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Alabama

1(800)243-5463

Alaska

1(800)478-6065 in-state calls only

American Samoa

Phone number not available

Arizona

1(800)432-4040

Arkansas

1(800)224-6330

California

1(800)434-0222 in-state calls only

Colorado

1(888)696-7213

Connecticut

1(800)994-9422 in-state calls only

Delaware

1(800)336-9500 in-state calls only

Florida

1(800)963-5337

Georgia

1(800)669-8387

Guam

1(671)735-7382

Hawaii

1(888)875-9229

Idaho

1(800)247-4422 in-state calls only

Illinois

1(800)548-9034 in-state calls only

Indiana

1(800)452-4800

Iowa

1(800)351-4664

Kansas

1(800)860-5260

Kentucky

1(877)293-7447

Louisiana

1(800)259-5301 in-state calls only

Section 11: For More Information



State Health Insurance Assistance Program: For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Maine

1(800)750-5353 in-state calls only

Maryland

1(800)243-3425 in-state calls only

Massachusetts

1(800)243-4636

Michigan

1(800)803-7174

Minnesota

1(800)333-2433

Mississippi

1(800)948-3090

Missouri

1(800)390-3330

Montana

1(800)551-3191 in-state calls only

Nebraska

1(800)234-7119

Nevada

1(800)307-4444

New Hampshire

1(800)852-3388 in-state calls only

New Jersey

1(800)792-8820 in-state calls only

New Mexico

1(800)432-2080 in-state calls only

New York

1(800)333-4114

North Carolina

1(800)443-9354 in-state calls only

North Dakota

1(800)247-0560

Northern Mariana Islands

Phone number not available

Ohio

1(800)686-1578

Oklahoma

1(800)763-2828 in-state calls only

Oregon

1(800)722-4134 in-state calls only

Section 11: For More Information

State Health Insurance Assistance Program: For help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Pennsylvania

1(800)783-7067

Puerto Rico

1(877)725-4300

Rhode Island

1(401)462-0508

South Carolina

1(800)868-9095

South Dakota

1(800)536-8197

Tennessee

1(877)801-0044

Texas

1(800)252-9240

Utah

1(800)424-4640

Vermont

1(800)642-5119 in-state calls only

Virgin Islands

1(340)776-8311 -1005

Virginia

1(800)552-3402

Washington

1(800)562-6900

Washington D.C.

1(202)739-0668

West Virginia

1(877)987-4463

Wisconsin

1(800)242-1060

Wyoming

1(800)856-4398

Definitions of Words in Blue

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Section

Appeal—A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare or your health plan. You can appeal if you request a health care service, supply or prescription that you think you should be able to get, or you request payment for health care you already received, and Medicare or a health plan denies the request. You can also appeal if you are already receiving coverage and the plan stops paying. There is a specific process your Medicare Advantage Plan, other Medicare Health Plan, Medicare drug plan, or the Original Medicare Plan must use when you ask for an appeal.

Benefit Period—The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Coinsurance—The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Copayment—In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount you pay. For example, this could be \$10 or \$20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Creditable Prescription Drug

Coverage—Prescription drug coverage (like from an employer or union), that is, on average, at least as good as the Medicare standard prescription drug coverage.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan or other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Section 12: Definitions of Words in Blue

Formulary—A list of certain kinds of prescription drugs that a Medicare drug plan will cover subject to limits and conditions.

Health Maintenance Organization

Plan—A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Institution—A facility that meets Medicare's definition of a long-term care facility, such as a nursing home or skilled nursing facility. Doesn't include assisted or adult living facilities, or residential homes.

Long-term Care—A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Medicaid—A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary—Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Medicare Advantage Plan—A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare-approved Amount—In the Original Medicare Plan, this is the amount a doctor or supplier can be paid, including what Medicare pays and any deductible, coinsurance, or copayment that you pay.

Medicare Cost Plan—A Medicare Cost Plan is a type of HMO. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan, except your plan pays for emergency services, or urgently needed services outside the service area.

Medicare Health Plan—A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible for a plan in their area, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Plan

A stand-alone drug plan, offered by insurance and other private companies to add prescription drug coverage to the Original Medicare Plan, Medicare Private Fee-for-Service Plans that don't have prescription drug coverage, and Medicare Cost Plans.

Medigap Policy—Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Original Medicare Plan—A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Penalty—An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan, if you don't join when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions.

Point-of-Service—An HMO option that lets you use doctors and hospitals outside the plan for an additional cost.

Preferred Provider Organization Plan—A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Private Fee-for-Service Plan—A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Section 12: Definitions of Words in Blue

Referral—A written OK from your primary care doctor for you to see a specialist or get certain services. In many HMOs, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.

Skilled Nursing Facility Care—This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff and that, as a practical matter, can't be provided on an outpatient basis. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.

Special Needs Plan—A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.

State Health Insurance Assistance Program—A State program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Telemedicine—Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

TTY—A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.

Important Telephone Numbers

Name	Telephone Number
Your Doctor	
Your Doctor	
Your Doctor	
Your Dentist	
Your Pharmacy	
Medicare Helpline For help with questions about Medicare.	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security Administration For help with questions about eligibility for and enrolling in Medicare, Social Security retirement benefits, or disability benefits.	1-800-772-1213 TTY 1-800-325-0778

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HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850**

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- **www.medicare.gov on the web**
- **1-800-MEDICARE (1-800-633-4227)**
- **TTY 1-877-486-2048**

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in Braille, Large Print (English
and Spanish), or Spanish, visit
www.medicare.gov on the web,
or call 1-800-MEDICARE
(1-800-633-4227). TTY users
should call 1-877-486-2048.**

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disponible en audiocasete y
letra grande. Llame gratis al
1-800-MEDICARE
(1-800-633-4227). Las personas
que usan TTY deben llamar al
1-877-486-2048.**